RESOURCE AND PATIENT MANAGEMENT SYSTEM

IHS PCC Suite

(BJPC)

Health Summary User Manual

Version 2.0 Patch 8
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Office of Information Technology (OIT)
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Preface

This manual provides information specific to the Patient Care Component Health Summary System, including generating health summaries. This manual also provides information on customizing health summaries with measurement panels, flowsheets, and health maintenance reminders.

1.0 Introduction

The Patient Care Component (PCC) database is the central repository for data in the Resource and Patient Management System (RPMS).

The following RPMS components comprise the PCC suite:

- IHS Dictionaries (AUPN)
- Standard Tables
- PCC Health Summary, including Health Maintenance Reminders (APCH)
- PCC Data Entry (APCD)
- PCC Management Reports, including PGEN/VGEN (APCL)
- Designated Specialty Provider Management (DP)
- QMan (Query Manager) (AMQQ)
- Taxonomy Management (ATX)

The Health Summary System allows users to quickly generate a summary of a patient's demographic and clinical information from the PCC of the RPMS database. This user manual explains in detail the elements that make up health summaries and explains how to generate health summaries. Also included are instructions for creating locally defined health summaries, and components for site and clinic-specific needs. This manual was written specifically for healthcare providers, site managers, and other clinical and administrative staff members who generate and use health summaries.

The PCC Health Summary is a clinically oriented, structured report that extracts a variety of data for a single patient from the PCC database and displays it in a standard format. The data displayed for the patient cover a range of health-related information, including demographic data, allergies, current medical problems, health history, and the purposes of previous visits.

Demographic data are entered into the RPMS database through the IHS Registration System at a patient's initial encounter in a clinic or hospital and are updated after subsequent patient visits. Health information is collected during clinic, field, and administrative contacts with patients through the Indian Health Service (IHS) direct, tribal, and contract healthcare programs. Data obtained from these contacts are recorded by healthcare providers on the PCC Encounter Form and entered into the PCC database by the data entry staff. These types of data are then retrieved from the PCC and printed in the Health Summary to provide an overview of an individual patient's health and previously received IHS services.

The Health Summary assists providers with the delivery of comprehensive healthcare to each patient at every visit. It allows the provider to recognize patient problems other than the presenting complaint and to meet the patient's preventive healthcare needs. The summary also offers a means of communication among the various healthcare providers that an individual patient might see.

The key elements of the Health Summary provide:

- A structured and summarized overview of the health status, health experiences, and preventive health needs of each patient
- Health data from sources of care not normally contained in the patient chart
- An index to the patient chart through the highlighting of significant events and dates

A PCC Health Summary is routinely printed whenever a patient is seen by a provider in the emergency room, outpatient clinic, or in the field. The Health Summary can also be displayed for review on a video terminal.

> **Note**: PCC Health Summaries are highly confidential documents and should be afforded the same security measures as patient health records.

When prompted to enter the patient name, use the following guidelines:

- Type the patient's name or a portion of the name in the following format: HORSECHIEF,JOHN DOE or HORSECHIEF,JOHN. Follow these guidelines:
  - Use from 3 to 30 letters
  - A comma must follow the last name
  - If 'JR' or 'II', etc., is included, follow the format SMITH,JOHN MARK,JR.
  - No spaces after commas.
  - Type the patient's IHS Chart Number
- Type the patient's date of birth (DOB) in one of the following formats: B012266 or any valid date, e.g. 01/22/66, 01-22-66, or JAN 22,1966
- Type the patient's Social Security Number (SSN) or the last four digits of the SSN
- If the patient is an inpatient, specify the ward or room-bed in the format 66-2 PEDIATRICS

During data input, the help screen can be accessed by typing two question marks (**??**) at the specific prompt. In some cases, the valid entries for the data will display.

Some prompts ask the user to type a date. Examples of valid dates are as follows:

- JAN 20 1957, 20 JAN 57, 1/20/57, or 012057

- T (for today), T+1 (for tomorrow), T+2, T+7, etc.
- T-1 (for yesterday), T-3W (for 3 weeks ago), etc.
- If the year is omitted, the computer assumes a date in the past.
- The user may omit the precise day; for example, JAN, 1957.

2.0 Release Notes

BJPC v2.0 patch 8 contains the following modifications and enhancements

2.1 PCC Data Entry (APCD)

The following changes apply to the APCD application.

2.1.1 Mnemonics: New

PHQT: PHQ-9 Modified for Teens

2.1.2 Mnemonics: Modified

- GP Eyeglass Prescription new/changed fields:
  - RE Prism H
  - RE Prism V
  - LE Prism H
  - LE Prism V
  - PD (distance)
  - PD (near)
  - PD (left)
  - PD (right)
  - COMMENT
- ACTH Anti-Coagulation Therapy new field
  - Comment

2.2 PCC Health Summary (APCH)

The following modifications apply to the APCH application.

2.2.1 Health Summary Modifications

Added the comment field for the last ANT entry to the Anticoagulation Patient Care Supplement.

2.2.2 Best Practice Prompts

- Changed the logic for the Anti-Coagulation Best Practice Prompts. The system now checks V Medication for warfarin prescribed in the past 120 days instead of 365 days. The system checks if the last warfarin order in that time period is discontinued.

- The logic description for the Anti-Coagulation Best Practice Prompts is updated to reflect the logic change.

2.2.3 Patient Wellness Handout

- Allergies inactivated through the ART application no longer display in the PWH "Allergies" component.
- Corrects issue on the Adult Ht/Wt/BMI component where text based on the BMI calculation displayed incorrectly.
- Corrects issue on Pediatric WT/HT/HC component where incorrect message displayed if HT not entered.
- NVA meds display logic modified to look at whether med is discontinued, instead of 365 day time period.

2.3 PCC Management Reports (APCL)

The following changes apply to the APCL application.

2.3.1 VGEN

Added PHQT to VGEN Measurements selection list.

2.3.2 Patient Management Report Changes

- Added PHQ-9 Measurement to depression screening logic for the five Depression Screening reports under the DEP menu option.
- Modified the Alcohol and Depression Screening reports to look at the Encounter Provider field rather than the Ordering Provider field when listing which provider performed the screening.
- Corrected a misspelling in the header of the Deceased Patient Reports

2.4 V Files

2.4.1 New V File Fields

- Added four new fields to each V File:
  - Date/Time Entered (#1216) - Stuffed with the system time of entry (Now)
  - Entered By (#1217) - Stuffed with logged in user
  - Date/Time Last Modified (#1218) - Stuffed with the system time of modification (NOW)
  - Last Modified by (#1218) - Stuff with logged in user

3.0 Health Summary (APCH)

The Health Summary System allows users to generate a summary of a patient's demographic and clinical information. This manual explains the elements that make up health summaries and explains how to generate health summaries. Included are instructions for creating locally defined health summaries, and components for site and clinic-specific needs.

The example below shows the Health Summary menu options.

```
                  ************************************
                  **       IHS Health Summary       **
                  ************************************
                         IHS PCC Suite Version 2.0

                               DEMO HOSPITAL


 HS    Generate Health Summary
 BRHS  Browse Health Summary
 MHS   Generate Multiple Health Summaries
 CRHS  Health Summary Displaying CMS Register(s)
 INHS  Health Summary for Inactive Patient
 BLD   Build Health Summary ...
 GSUP  Generate a Health Summary Supplement
 HSM   Health Summary Maintenance ...
 MPWH  Patient Wellness Handout Menu ...
 PWH   Generate a Patient Wellness Handout

Select Health Summary Menu Option:
```

Figure 3-1: IHS Health Summary menu options

This section covers the following options in the Health Summary Menu: Generate Health Summary (HS), Browse Health Summary (BRHS), Generate Multiple Health Summaries (MHS), Health Summary Displaying CMS Register(s) (CRHS), Health Summary for Inactive Patients (INHS), Generate a Health summary Supplement, and Generate a Patient Wellness Handout (PWH).

This section does *not* cover the following options: Build Health Summary (BLD), Health Summary Maintenance (HSM), and Patient Wellness Handout Menu (MPWH). These options are located in Sections 4.0, 5.0, and 6.0 of this manual, respectively.

Note: Appendix H: contains descriptions of all the available health summary components.

3.1 Generate Health Summary (HS)

Use the HS option to generate a health summary for a single patient. Follow these steps:

1. At the “Select Health Summary Menu Option” prompt, type **HS.**
2. At the “Select health summary type” prompt type the name of the health summary type. To accept the default health summary type (Adult Regular), press Enter. Refer to Section 5.0 to learn more about working with health summary types.
3. At the “Select patient” prompt, type the name or health record number of the patient for whom the health summary will be generated.
4. At the “DEVICE” and “Right Margin” prompts, indicate the device and margins to display/print the report, or press Enter to accept the default values

Below is an example of an Adult Regular Health Summary.

```
                              ************************************
                              **       IHS Health Summary       **
                              ************************************
                                    IHS PCC Suite Version 2.0

                                       DEMO HOSPITAL


  HS    Generate Health Summary
  BRHS  Browse Health Summary
  MHS   Generate Multiple Health Summaries
  CRHS  Health Summary Displaying CMS Register(s)
  INHS  Health Summary for Inactive Patient
  BLD   Build Health Summary ...
  GSUP  Generate a Health Summary Supplement
  HSM   Health Summary Maintenance ...
  MPWH  Patient Wellness Handout Menu ...
  PWH   Generate a Patient Wellness Handout

Select Health Summary Menu Option: HS Generate Health Summary

* * * H E A L T H S U M M A R Y P R O G R A M (2.0) * * *


Select health summary type: ADULT REGULAR//
Select patient: BETA,JANE 111
Patient's chart number is 111

DEVICE: HOME//  VT  Right Margin: 80//
```

Figure 3-2: Health Summary Menu

```
** CONFIDENTIAL PATIENT INFORMATION -- 11/2/2009 10:29 AM [XX] ****
********* BETA,JANE #111 (ADULT REGULAR SUMMARY) pg 1 *********
```

```
-------------------- DEMOGRAPHIC DATA -----------------------------

BETA, JANE     DOB: AUG 1,1978 31 YRS FEMALE no blood type
DOWN EAST BAND OF LOCALS IND. RES SSN: XXX-XX-7347
         MOTHER'S MAIDEN NAME: SMITH,JOAN
(H) 555-555-5555


LAST UPDATED: OCT 21,2009   ELIGIBILITY: CHS & DIRECT
NOTICE OF PRIVACY PRACTICES REC'D BY PATIENT?
     DATE RECEIVED BY PATIENT:
     WAS ACKNOWLEDGEMENT SIGNED?

HEALTH RECORD NUMBERS: 106931 DEMO HOSPITAL
DESIGNATED PRIMARY CARE PROVIDER: <none identified>
------------- ALLERGIES (FROM PROBLEM LIST) -----------------------


        ***** ASA *****


-- ALLERGIES/ADVERSE REACTIONS (FROM ALLERGY TRACKING) ------------


      NO ALLERGY INFORMATION RECORDED

------ MEASUREMENT PANELS (max 5 visits or 2 years) ---------------


   HT WT  BP  BMI  %RW   VU    VC
   VC
05/21/01  121 127/85  ***  ***

*** NO HEIGHT FOR PATIENT.
------------- ALLERGIES (FROM PROBLEM LIST) -----------------------


        ***** ASA *****


-- ALLERGIES/ADVERSE REACTIONS (FROM ALLERGY TRACKING) ------------


      NO ALLERGY INFORMATION RECORDED

------ MEASUREMENT PANELS (max 5 visits or 2 years) --------------


   HT WT  BP  BMI  %RW   VU    VC
   VC
05/21/01  121 127/85  ***  ***

*** NO HEIGHT FOR PATIENT.
------ MEDS - MOST RECENT OF EACH (max 1 year) ------------------
```

```
 SCHEDULED ENCOUNTERS (INCLUDES CHART REQ AND WALK INS) (max 10
visits or 90 days)


----- IN HOSPITAL VISITS (max 10 visits or 2 years) ---------------


--- OUTPATIENT/FIELD VISITS (max 10 visits or 2 years) ------------

10/11/09 DEMO HOSP    <purpose of visit not yet entered>


      <<< RCIS ACTIVE REFERRALS >>>
--------- REFERRED CARE (max 10 visits or 2 years) -----------------


No Referred Care Referral records on file.

----------- TREATMENTS PROVIDED (max 25 visits) --------------------

11/27/95 DEMO HOSP TONOMETRY (1)

- MOST RECENT RADIOLOGY STUDIES (max 10 visits or 5 years) ---------



--------- MOST RECENT LABORATORY DATA (max 1 year) -----------------

 TEST     RESULT DT/TIME VISIT RESULT  UNITS  REF RANGE
----------------- MOST RECENT EXAMINATIONS -------------------------

VISION EXAM [Dx: V72.0]    09/10/01
TONOMETRY       09/10/01
NEWBORN HEARING SCREEN (LEFT   10/11/09 NORMAL/NEGATIVE
EPPROVIDER,IRFA

--------------------- IMMUNIZATIONS -------------------------------

 IMMUNIZATION FORECAST:

  Tdap    past due

 IMMUNIZATION HISTORY:

  Td-ADULT    05/11/98 19 yrs Demo Hospital

  OPV     11/02/95 17 yrs Demo Hospital
--------------------- IMMUNIZATIONS -------------------------------


  MMR     11/02/95 17 yrs Demo Hospital


-------------------- ALL SKIN TESTS -----------------------------
```

```
PPD   11/04/95 0 mm   DEMO HOSP


------------- HEALTH MAINTENANCE REMINDERS -----------------------

       LAST  NEXT

BLOOD PRESSURE   05/21/01 05/21/02
HEIGHT        08/29/78
-------------- HEALTH MAINTENANCE REMINDERS -----------------------


WEIGHT     05/21/01 05/21/02
PAP SMEAR       08/29/96

PELVIC EXAM       08/29/96
BREAST EXAM       08/29/98

DIABETES SCREENING     06/30/74
Tdap      past due

PHYSICAL EXAM      08/29/96

TD-ADULT     05/11/98 05/08/08
ALCOHOL USE SCREENING    08/29/91

TOBACCO USE SCREENING    08/29/91

-------------- HEALTH MAINTENANCE REMINDERS -----------------------

       LAST  NEXT

DOMESTIC VIOLENCE/IPV SCR   08/29/93
*** END CONFIDENTIAL PATIENT INFORMATION -- 11/2/2009 10:29 AM [XXX]
*******
```

Figure 3-3: Example of Adult Summary Regular

3.2 Browse Health Summary (BRHS)

Use the BRHS option to view a health summary report for a specific patient. This option is not available when generating multiple health summaries at the same time. Follow these steps:

1. At the “Select Health Summary Menu Option” prompt, type **BRHS**.
2. At the “Select health summary type” prompt, type the name of the health summary type. To accept the default health summary type (Adult Regular), press Enter. Refer to Section 5.0 to learn more about working with health summary types.

3. At the “Select Patient” prompt, type the name of the patient for whom the health summary will be generated. The report displays the OUTPUT BROWSER screen, as shown below.

Below is an example of the prompts and the initial information that displays in a patient’s health summary.

```
                                 ************************************
                            **       IHS Health Summary       **
                                 ************************************
                                       IHS PCC Suite Version 2.0

                                           DEMO HOSPITAL

  HS    Generate Health Summary
  BRHS  Browse Health Summary
  MHS   Generate Multiple Health Summaries
  GSUP  Generate a Health Summary Supplement
  CRHS  Health Summary Displaying CMS Register(s)
  INHS  Health Summary for Inactive Patient
  BLD   Build Health Summary ...
  HSM   Health Summary Maintenance ...
  MPWH  Patient Wellness Handout Menu ...
  PWH   Generate a Patient Wellness Handout

Select Health Summary Menu Option: BRHS Browse Health Summary

Select health summary type: ADULT REGULAR//
Select patient: SMITH,JOHN
 SMITH,JOHN          M 12-14-2001 XXX-XX-0740 DEMO 116257
Patient's chart number is 116257


+  NEXT SCREEN     -  PREVIOUS SCREEN   Q  QUIT

OUTPUT BROWSER        Feb 04, 2010 09:35:25     Page:  1 of  8
PCC Health Summary for SMITH,JOHN


******** CONFIDENTIAL PATIENT INFORMATION -- 2/4/2010 9:35 AM [LAF]
********
******** SMITH,JOHN #116257  (ADULT REGULAR SUMMARY) pg 1 ********

-------------------- DEMOGRAPHIC DATA --------------------------

SMITH,JOHN        DOB: DEC 14,2001 8 YRS  MALE  no blood type
CHIPPEWA TRIBE OF MN, LEECH LAKE SSN: XXX-XX-0740
                 MOTHER'S MAIDEN NAME: WILSON,JANE
(H) 555-555-4935         FATHER'S NAME: SMITH,JAMES
SOMEWHERE (PO BOX 243,SOMEWHERE,MN,56671)
```

Figure 3-4: Example of browsing a health summary

The following options are available in the OUTPUT BROWSER screen:

- Type **Q** (Quit) to exit the OUTPUT BROWSER screen and return to the "Select Health Summary Menu Option" prompt.
- Type a plus sign (+) to display the next screen. This option is not available for the last screen.
- Type a minus sign (-) to display the previous screen. This option is not available for the first screen.

3.3 Generate Multiple Health Summaries (MHS)

The multiple health summaries (MHS) option generates health summaries for multiple patients. Follow these steps:

1. At the "Select Health Summary Menu Option" prompt, type **MHS**.
2. At the "Select health summary type" prompt, type the name of the health summary type. To accept the default health summary type (Adult Regular), press Enter. Refer to Section 5.0 to learn more about working with health summary types.
3. At each "Select Patient(s)" prompt, type the name of the patient for whom the health summary will be generated.
4. When all patients have been added, press Enter at the "Select Patients(s)" prompt.
5. At the "Device" prompt, select the device to display/print the report.
6. At the "<>" prompt, press Enter to view the next page of the report.

The application displays the reports. Below is an example of the prompts and the initial information that displays in the first patient's health summary.

```
  HS    Generate Health Summary
  BRHS  Browse Health Summary
  MHS   Generate Multiple Health Summaries
  CRHS  Health Summary Displaying CMS Register(s)
  INHS  Health Summary for Inactive Patient
  BLD   Build Health Summary ...
  GSUP  Generate a Health Summary Supplement
  HSM   Health Summary Maintenance ...
  MPWH  Patient Wellness Handout Menu ...
  PWH   Generate a Patient Wellness Handout

Select Health Summary Menu Option: MHS Generate Multiple Health
Summaries

* * * B A T C H H E A L T H S U M M A R Y P R O G R A M * * *


Select health summary type: ADULT REGULAR//
Select patient(s): SMITH,JOHN
  1  SMITH,JOHN M 06-20-2001 XXX-XX-0109 DEMO 116015
```

```
  2  SMITH,JAMES M 12-14-2001 XXX-XX-0740 DEMO 116257
CHOOSE 1-2: 1
 SMITH,JOHN M 06-20-2001 XXX-XX-0109 DEMO 116015
Select patient(s): SMITH,JAMES
  1  SMITH,JAMES           M 10-01-1979 XXX-XX-4500 DEMO 104453
CHOOSE 1-5: 1

Select patient(s):

DEVICE: HOME//  VT

* CONFIDENTIAL PATIENT INFORMATION -- 2/4/2010 9:40 AM [LAF]*
 SMITH,JOHN WINTERHAWK #116015  (ADULT REGULAR SUMMARY) pg 1 *

-------------------- DEMOGRAPHIC DATA -----------------------------

SMITH,JOHN DOB: JUN 30,2001 8 YRS  MALE  no blood type
DOWN EAST BAND OF LOCALS IND. RES SSN: XXX-XX-0109
                 MOTHER'S MAIDEN NAME: WILSON,JANE
(H) 555-555-4344         FATHER'S NAME: SMITH,WILLAIM
>>
```

Figure 3-5: Example of Page 1 of a multiple page ADULT REGULAR SUMMARY report

3.4 Health Summary Displaying CMS Register(s) (CRHS)

The CRHS option generates a Health Summary that displays a CMS register for a specific patient. Follow these steps:

1. At the “Select Health Summary Menu Option” prompt, type **CRHS**.
2. At the “Select Patient” prompt, type the name of the patient.
3. At the “Select health summary type” prompt, type the name of the health summary type. To accept the default health summary type (Adult Regular), press Enter. Refer to Section 5.0 to learn more about working with health summary types.

Below is an example of the CMS Registers health summary.

```
  HS    Generate Health Summary
  BRHS  Browse Health Summary
  MHS   Generate Multiple Health Summaries
  CRHS  Health Summary Displaying CMS Register(s)
  INHS  Health Summary for Inactive Patient
  BLD   Build Health Summary ...
  GSUP  Generate a Health Summary Supplement
  HSM   Health Summary Maintenance ...
  MPWH  Patient Wellness Handout Menu ...
  PWH   Generate a Patient Wellness Handout

Select Health Summary Menu Option: CRHS Health Summary Displaying
CMS Register(s)
```

```
* * * H E A L T H S U M M A R Y P R O G R A M (2.0) * * *


Select patient: SMITH,JOHN

 SMITH,JOHN      M 06-20-2001 XXX-XX-0109 DEMO 116015
Patient's chart number is 116015

Select health summary type: ADULT REGULAR//
DEVICE: HOME//  VT  Right Margin: 80//

 CONFIDENTIAL PATIENT INFORMATION -- 2/4/2010 9:43 AM [LAF] ********
 SMITH,JOHN WINTERHAWK #116015  (ADULT REGULAR SUMMARY) pg 1 *******

--------------------- DEMOGRAPHIC DATA ----------------------------

SMITH,JOHN WINTERHAWK       DOB: JUN 20,2001 8 YRS  MALE  no blood
type
DOWN EAST BAND OF LOCALS IND. RES SSN: XXX-XX-0109

LAST UPDATED: JUL 24,2006   ELIGIBILITY: INELIGIBLE

NOTICE OF PRIVACY PRACTICES REC'D BY PATIENT?
     DATE RECEIVED BY PATIENT:
     WAS ACKNOWLEDGEMENT SIGNED?

HEALTH RECORD NUMBERS: 172684 DEMO HOSPITAL
DESIGNATED PROVIDER: <none identified>
----------------- INSURANCE INFORMATION ------------------------

INSURANCE   NUMBER SUFF COV EL DATE SIG DATE END DATE
NC MEDICAID  133080944  IC  06/01/06
 Plan Name: ALL STATES COVERAGE INC

---- PATIENT WELLNESS HANDOUT TALLY (max 10 visits or 2 years) ----


No Patient Wellness Handouts given to this patient.

------- ALLERGIES/ADVERSE REACTIONS (FROM ALLERGY TRACKING) -------


    NO ALLERGY INFORMATION RECORDED

---------------- ALLERGIES (FROM PROBLEM LIST) ----------------



      ***** NONE RECORDED *****

---------- MEASUREMENT PANELS (max 5 visits or 2 years) ----------


   HT WT  BP  BMI  %RW   VU  VC
```

```
07/20/06  10     ***  ***

*** NO HEIGHT FOR PATIENT.


----------- HEALTH FACTORS (max 10 visits or 2 years) -----------


------ OUTPATIENT/FIELD VISITS (max 10 visits or 2 years) ------



    <<< RCIS ACTIVE REFERRALS >>>

BEGIN DOS:       DISCHARGE CONSULT DT:
DATE REFERRED: 7/17/2008    CHS STATUS: PENDING
          MCC ACTION:
REFERRED BY: GEBREMARIAM,CINDY  REFERRED TO: CHEROKEE DIALYSIS
CENTER
PURPOSE: DIALYSIS TX
DIAGNOSTIC CATEGORY:  NEPHROLOGICAL AND UROLOGICAL DISORDERS

----- MOST RECENT PATIENT EDUCATION (max 5 visits or 2 years) -----



---- MOST RECENT RADIOLOGY STUDIES (max 10 visits or 2 years) ----



----------------- MOST RECENT EXAMINATIONS ------------------
-------------------- IMMUNIZATIONS --------------------------

 IMMUNIZATION FORECAST:
  HEP B PED   past due
  DTaP    past due
  HIB NOS   due
  IPV    past due
  MMR    past due
  VARICELLA   past due

------------------------ IMMUNIZATIONS -------------------------

  HEP A PED   past due
  PNEUM-CONJ   past due



  FLU-SPLIT   due

 IMMUNIZATION HISTORY:


------------------ HEALTH MAINTENANCE REMINDERS ------------------
```

```
       LAST  NEXT

HEIGHT        MAY BE DUE NOW
WEIGHT     07/20/06 MAY BE DUE NOW (WAS DUE 07/20/07)

HCT/HGB        MAY BE DUE NOW (WAS DUE 03/14/07)
HEP B PED    past due

----------------- HEALTH MAINTENANCE REMINDERS -----------------

       LAST  NEXT

DTaP      past due
HIB NOS     due
IPV      past due
MMR      past due
VARICELLA    past due
HEP A PED    past due
PNEUM-CONJ    past due
FLU-SPLIT    due

HEAD CIRCUMFERENCE    MAY BE DUE NOW (WAS DUE 03/14/06)
HEARING TEST     MAY BE DUE NOW

TOBACCO USE SCREENING  07/11/06 MAY BE DUE NOW (WAS DUE 01/10/07)
Women's Health Profile not available.
Women's Health Profile not available.
END CONFIDENTIAL PATIENT INFORMATION -- 12/10/2008 9:00 AM [SJT] ***
<>
Select patient:
```

Figure 3-6: Health Summary Displaying CMS Register(s) (CRHS)

3.5 Health Summary for Inactive Patients (INHS)

Use the INHS option to generate a Health Summary for Inactive Patients. Follow the steps below:

1. At the “Select Health Summary Menu Option” prompt, type **INHS**.
2. At the “Select health summary type” prompt, type the name of the health summary type. To accept the default health summary type (Adult Regular), press Enter. Refer to Section 5.0 to learn more about working with health summary types.
3. At the “Select Patient” prompt, type the name of the patient for whom the health summary will be generated. If all patients are to be looked up, the application will display (I) at the end of the HRN #, for example:

   ADAMS,DEBBIE F 08-15-1973 XXX-XX-1819 CIMD 103610(I)

Below is an example of the prompts, and the display of the Inactive Patients health summary.

```
  HS    Generate Health Summary
  BRHS  Browse Health Summary
  MHS   Generate Multiple Health Summaries
  CRHS  Health Summary Displaying CMS Register(s)
  INHS  Health Summary for Inactive Patient
  BLD   Build Health Summary ...
  GSUP  Generate a Health Summary Supplement
  HSM   Health Summary Maintenance ...
  MPWH  Patient Wellness Handout Menu ...
  PWH   Generate a Patient Wellness Handout

Select Health Summary Menu Option: INHS Health Summary for Inactive
Patient

* * * H E A L T H S U M M A R Y P R O G R A M (2.0) * * *


Select health summary type: ADULT REGULAR//
Select patient: SMITH,LISA
 SMITH,LISA           F 03-1-1927 XXX-XX-2501 DEMO 111(I)
Patient's chart number is 107333

DEVICE: HOME//  VT  Right Margin: 80//


 CONFIDENTIAL PATIENT INFORMATION -- 2/4/2010 9:46 AM [LAF] ********
********* SMITH,LISA #111  (ADULT REGULAR SUMMARY) pg 1 *********

-------------------- DEMOGRAPHIC DATA ----------------------------

SMITH,LIS         DOB: MAR 1,1927 82 YRS FEMALE no blood type
CHIPPEWA TRIBE OF MN, LEECH LAKE SSN: XXX-XX-2501
LAST UPDATED: JUN 25,2003   ELIGIBILITY: PENDING VERIFICATION

NOTICE OF PRIVACY PRACTICES REC'D BY PATIENT?
     DATE RECEIVED BY PATIENT:
     WAS ACKNOWLEDGEMENT SIGNED?

HEALTH RECORD NUMBERS: 155242 DEMO INDIAN HOSPITAL
      155243 DEMO HOSPITAL
      155244 DEMO HEALTH & MEDICAL DIV
        DESIGNATED PROVIDERS
------------------------- DEMOGRAPHIC DATA ------------------------

        DIABETES: TQPROVIDER,LIZ
     CHEMICAL DEPENDENCY: JKPROVIDER,HILLANE S
       MENTAL HEALTH: KWPROVIDER,BLAKE
       CASE MANAGER:

--- PATIENT WELLNESS HANDOUT TALLY (max 10 visits or 2 years) ---

PATIENT WELLNESS HANDOUT TYPE # given Dates Last 4 Given to Patient
```

```
-------------------------------------------------------------------
 ADULT REGULAR     1  12/09/08


------ ALLERGIES/ADVERSE REACTIONS (FROM ALLERGY TRACKING) -------

      NO ALLERGY INFORMATION RECORDED

------------------ ALLERGIES (FROM PROBLEM LIST) ------------------



------------------ ALLERGIES (FROM PROBLEM LIST) ------------------


       ***** NONE RECORDED *****


----------- MEASUREMENT PANELS (max 5 visits or 2 years) -----------


  HT WT  BP  BMI  %RW   VU   VC
12/18/98  74   ***  ***

*** NO HEIGHT FOR PATIENT.


----------- HEALTH FACTORS (max 10 visits or 2 years) -----------


~~ TOBACCO ~~
04/14/08 NON-TOBACCO USER

------- OUTPATIENT/FIELD VISITS (max 10 visits or 2 years) -------

02/25/08 DEMO HO  OT  SOCIAL SERVICE VISIT
        SOCIAL SERVICE VISIT
   ANALENISGI MH  MENTAL HEALTH VISIT


      <<< RCIS ACTIVE REFERRALS >>>

No Referred Care Referral records on file.


----- MOST RECENT RADIOLOGY STUDIES (max 10 visits or 2 years) -----


MAMMOGRAM BILAT  (04/14/08) RESULT: NORMAL

 IMPRESSION:
SCREENING MAMMOGRAM (04/17/08) RESULT: NORMAL

 IMPRESSION:
```

```
----------- LABORATORY DATA (max 10 visits or 2 years) -----------


           04/14/08
PAP SMEAR, CONVENTIONAL     normal


-------------------- MOST RECENT EXAMINATIONS --------------------

DEPRESSION SCREENING   04/14/08 NORMAL/NEGATIVE

------------------------- IMMUNIZATIONS -------------------------

 IMMUNIZATION FORECAST:

  Tdap    due


 IMMUNIZATION HISTORY:



------------------- HEALTH MAINTENANCE REMINDERS -------------------

       LAST  NEXT

BLOOD PRESSURE 12/18/98 12/18/99


------------------ HEALTH MAINTENANCE REMINDERS ------------------

       LAST  NEXT

HEIGHT    12/18/98 12/18/99
WEIGHT    12/18/98 12/18/99

PAP SMEAR  12/18/98 12/18/99
DOMESTIC VIOLENCE/IPV SCR 12/18/98 12/18/99

Tdap      due

TD-ADULT       04/15/09
TOBACCO USE SCREENING  04/14/08 04/15/09

ALCOHOL USE SCREENING 04/14/09
DEPRESSION SCREENING  04/14/08 04/14/09

Women's Health Profile not available.
Women's Health Profile not available.
*** END CONFIDENTIAL PATIENT INFORMATION -- 12/10/2008 9:12 AM [SJT]
*******
<>
Select patient:
```

Figure 3-7: Inactive Patients health summary

3.6 Build Health Summary (BLD)

Use the BLD option to build a Health Summary. Refer to Section 4.0 for detailed information.

3.7 Generate a Health Summary Supplement (GSUP)

Use the GSUP option to generate a standalone Health Summary Supplement without generating a Health Summary.

> **Note**: This option does not perform a diagnosis check determine if the supplement is appropriate for the patient.

1. At the "Select Health Summary Menu Option" prompt, type **GUSP**
2. At the "Select Patient Name" prompt, type a patient name
3. At the "Select HEALTH SUMMARY SUPPLEMENT NAME:

3.8 Health Summary Maintenance (HSM)

Use the HSM option to manage Health Summary types. Refer to Section 5.0 for detailed information.

3.9 Patient Wellness Handout Menu (MPWH)

Refer to Section 6.0, Patient Wellness Handout Menu, for detailed information about the menu structure. Refer to Appendix H: for detailed information about the PWH components and logic.

3.10 Generate a Patient Wellness Handout (PWH)

Use the PWH option to generate a Patient Wellness Handout. Refer to Section 6.0, Patient Wellness Handout Menu, for more information about PWH options. Refer to Appendix H for detailed information about the PWH components and logic.

To generate a PWH, follow these steps:

1. At the "Select Health Summary Menu Option" prompt, type **PWH**.
2. At the "Select Patient Wellness Handout Type" prompt, specify the type of PWH to generate. Adult Regular is the default value. To generate a Patient Wellness Handout that is not the default (e.g., a customized handout), specify the name of the handout and press Enter. Refer to Section 6.0 for more information.

3. At the “Select Patient” prompt, specify the patient.
4. At the “Select one of the following” prompt, type one of the following two options: **P** (Print Output) or **B** (Browse Output on Screen).

Detailed instructions for the Print Option are found below.

- **P** (Print) sends the report file to your printer, your screen, or an electronic file.
- **B** (Both) produces both a printed report and a delimited file.

> **Note:** If you want to print to a file and do not know your printer name, check with the site manager.

If you choose the Browse Output on Screen option, an action bar displays at the bottom of the screen. At the “Select Action” prompt, do one of the following:

- Type **Q** (Quit) to exit the Output Browser screen and return to the “Select Health Summary Menu Option” prompt.
- Type a plus sign (+) and press Enter to display the next screen. This option is not available for the last screen.
- Type a minus sign (–) and press Enter to display the previous screen. This option is not available for the first screen.

If the user chooses the Print Output option, at the “Enter RETURN to continue or '^' to exit” prompt, press Enter to continue to the next page of the handout or type a caret (^) to exit.

Below is an example of the prompts and the initial information in an Adult Regular Wellness Handout.

```
  HS    Generate Health Summary
  BRHS  Browse Health Summary
  MHS   Generate Multiple Health Summaries
  CRHS  Health Summary Displaying CMS Register(s)
  INHS  Health Summary for Inactive Patient
  BLD   Build Health Summary ...
  GSUP  Generate a Health Summary Supplement
  HSM   Health Summary Maintenance ...
  MPWH  Patient Wellness Handout Menu ...
  PWH   Generate a Patient Wellness Handout

Select Health Summary Menu Option: PWH Generate a Patient Wellness
Handout

             *** Patient Wellness Handout ***


Select Patient Wellness Handout type: ADULT REGULAR//

Select patient: SMITH,JANE
```

```
SMITH,JANE  F 03-17-1948 XXX-XX-6005 DEMO 106922
Patient's chart number is 106922

   Select one of the following:

     P     PRINT Output
     B     BROWSE Output on Screen

Do you wish to: P// RINT Output
DEVICE: HOME//  VT  Right Margin: 80//


My Wellness Handout             Report Date: Feb 04, 2010 Page: 1
-----------------------------------------------------------------


** CONFIDENTIAL PATIENT INFORMATION [LAF] Feb 04, 2010 **********

SMITH,JANE  HRN: 106922            RED LAKE HOSPITAL
PO BOX 000                    MN 11111
TOWN IN, MINNESOTA  11111           SJPROVIDER,KATHRYN A
555-555-5555

Thank you for choosing RED LAKE HOSPITAL.
This handout is a new way for you and your doctor to look at your
health.

_________________________________________________________________
HEIGHT/WEIGHT/BMI - Weight and Body Mass Index are good measures of
your health. Determining a health weight and Body Mass Index also
depends on how tall you are.

You are 5 feet and 5 inches tall.
Your last weight was 148 pounds on Jun 02, 2008.
You should have your weight rechecked at your next visit.

Enter RETURN to continue or '^' to exit:
```

Figure 3-8: Example of a Patient Wellness Handout (PWH)

4.0 Build Health Summary Menu (BLD)

The Health Summary system provides options to create custom Health Summaries that are site-specific and can be tailored to highlight the particular health needs of the patients in an area, or can focus on a particular diagnosis. For example, it may be necessary to create an Obstetrics Health Summary to provide a detailed printout of patients' prenatal visits and laboratory tests, or a Geriatrics Health Summary that focuses on the special needs of elderly patients.

The options to create a custom health summary type or build site-specific measurement panels and flowsheets are accessible from the Build Health Summary menu.

```
          ************************************
          **        IHS Health Summary       **
          ************************************
                       Version 2.0

                      DEMO HOSPITAL


 HS   Generate Health Summary
 BRHS Browse Health Summary
 MHS  Generate Multiple Health Summaries
 CRHS Health Summary Displaying CMS Register(s)
 INHS Health Summary for Inactive Patient
 BLD  Build Health Summary ...
 GSUP Generate a Health Summary Supplement
 HSM  Health Summary Maintenance ...
 MPWH Patient Wellness Handout Menu ...
 PWH  Generate a Patient Wellness Handout

Select Health Summary Menu Option:
```

Figure 4-1: Health Summary Menu options

To access options for building a Health Summary, at the "Select Health Summary Menu Option" prompt, type **BLD** and the following menu displays:

```
                            ************************************
                            **        IHS Health Summary       **
                            **    Build Health Summary Menu    **
                            ************************************
                                 IHS PCC Suite Version 2.0

                                     DEMO HOSPITAL

IS  Inquire About a Health Summary Type
PP  Print Health Maintenance Item Protocols
LS  List Health Summary Types
LC  List Health Summary Components
```

```
LM  List Measurement Panel Types
LF  List Health Summary Flowsheets
LI  List Health Summary Flowsheet Items
MS  Create/Modify Health Summary Type
MM  Create/Modify Measurement Panel
MF  Create/Modify Flowsheet
HS  Generate Health Summary
BRHS Browse Health Summary
FMMT Create/Modify Health Summary Type using Fileman
HSSP Update Health Summary Site parameters
PWH Patient Wellness Handout Menu ...

Select Build Health Summary Option:
```

Figure 4-2: Build Health Summary Menu (BLD)

4.1 Inquire About a Health Summary Type (IS)

Use the IS option to view the structure of a specific health summary type. The components that display in the health summary are the order of the components, data restrictions, and specifications regarding the display of the clinic name and ICD text. Follow these steps:

1. At the “Select Build Health Summary Option” prompt, type **IS**.
2. At the “Select Health Summary Type Name” prompt, specify the name of the desired health summary type.
3. At the “Device” prompt, specify the device to display/print the report.

Below is sample display for the specified health summary type.

```
HEALTH SUMMARY TYPE LIST                                        DEC
10,2008 09:43 PAGE 1
-----------------------------------------------------------------------


NAME: DENTAL LOCK: APCHZMGR
SUMMARY ORDER: 5 COMPONENT NAME: DEMOGRAPHIC DATA
SUMMARY ORDER: 9
 COMPONENT NAME: ALLERGIES/ADVERSE REACTIONS (BRIEF)
SUMMARY ORDER: 10
 COMPONENT NAME: ALLERGIES (FROM PROBLEM LIST)
SUMMARY ORDER: 20 COMPONENT NAME: PROBLEMS - ACTIVE
SUMMARY ORDER: 30 COMPONENT NAME: MEDS - CURRENT
 TIME LIMIT: 1Y
SUMMARY ORDER: 35 COMPONENT NAME: OUTPATIENT/FIELD VISITS
 MAXIMUM OCCURRENCES: 10 TIME LIMIT: 2Y
SUMMARY ORDER: 40 COMPONENT NAME: DENTAL
 MAXIMUM OCCURRENCES: 10 TIME LIMIT: 3Y
```

```
 ICD TEXT DISPLAYED: NONE PROVIDER NARRATIVE DISPLAYED: YES
 CLINIC DISPLAYED: YES
MEASUREMENT PANEL SEQUENCE: 1 MEASUREMENT PANEL TYPE: ADULT STD
```

Figure 4-3: Sample output of Inquire About a HEALTH SUMMARY TYPE (IS)

4. The user is returned to the “Select Health Summary Type Name” prompt, where another summary can be entered. If it is not necessary to review another summary, type a caret (^) to return to the “Select Build Health Summary Option” prompt.

4.2 Print Health Maintenance Item Protocols (PP)

Use the PP option to display or print the description/logic of all Health Summary Maintenance Reminders.

Health Maintenance Reminders are printed on many types of Health Summaries. The due dates for each item are calculated according to a predefined schedule. The PP option allows the user to review a schedule. Refer to Appendix A for more information about Health Maintenance Reminders. Follow these steps to use the PP option:

1. At the “Select Build Health Summary Option” prompt, type **PP**.
2. At the “Select one of the following” prompt, type either **P** (Print Output) or **B** (Browse Output on Screen).

Below is a sample of a HEALTH SUMMARY MAINTENANCE REMINDER in the OUTPUT BROWSER screen.

```
OUTPUT BROWSER                                  Dec 15, 2008 13:42:27  Page: 1 of 76



SJT              Page 1
                                DEMO HOSPITAL
                      HEALTH SUMMARY HEALTH MAINTENANCE REMINDERS

-------------------------------------------------------------------

Reminder:   ADULT MMR 1-DOSE VERSION
Status:   INACTIVE (OFF)

Description:
 Default Status: Off
 Denominator: Patients with no documented MMR since age 1 year:
 1. Born in 1957 or later who are at least 18; OR
 2. Females who were born in 1957 or earlier AND are currently less than age 50
years (NOTE: no longer applicable)
+ Enter ?? for more actions >>>
+ NEXT SCREEN   - PREVIOUS SCREEN  Q QUIT
Select Action: +//
```

Figure 4-4: Example Print Health Maintenance Item Protocols (PP)

The following actions can be performed in the OUTPUT BROWSER screen:

- Type **Q** (Quit) at the "Select Action" prompt to exit the OUTPUT BROWSER screen and return to the "Build Health Summary Option" prompt.
- Type a plus sign (+) to display the next screen. This option is not available for the last screen.
- Type a minus sign (-) to display the previous screen. This option is not available for the first screen.

4.3 List Health Summary Types (LS)

Use the LS option to view the names of all health summary types that exist at a user's facility. This list includes the standard health summary types distributed with this package, as well as any customized health summaries created locally. This list is pulled from the B index in the HEALTH SUMMARY TYPE file. Follow these steps:

1. At the "Select Build Health Summary Option" prompt, type **LS** to display list of health summary types.

The following is a portion of the health summary list.

```
Existing HEALTH SUMMARY TYPES:

  ADULT REGULAR
  ALL REMINDERS
  ANTICOAGULATION SERVICE
  BEHAVIORAL HEALTH
  BILLING
  CARDIOVASCULAR DISEASE
  CHR
  CURRENT MEDS ONLY
  DENTAL
  DENTAL CHART
  DENTAL VISIT
  DIABETES FLOW SHEET
Enter RETURN to continue or '^' to exit:
```

Figure 4-5: Example output of List Health Summary Types (LS)

4.4 List Health Summary Components (LC)

Use the LC option to view a list of the available health summary components. Follow these steps:

1. At the "Select Build Health Summary Option" prompt, type **LC** to display a list of existing health summary components. Refer to Appendix G for more information about the components.

The following is a portion of the health summary component list.

```
Existing HEALTH SUMMARY COMPONENTS:
  ACTIVE WAIT LIST ENTRIES
  ALLERGIES (FROM PROBLEM LIST)
  ALLERGIES/ADVERSE REACTIONS (B
  ALLERGIES/ADVERSE REACTIONS (D
  BEHAVIORAL HEALTH
  BLOOD BANK - MOST RECENT
  CHR
  CPT - ALL BY CPT CODE
  CPT - ALL BY DATE
  CPT - MOST RECENT OF EACH
  DEMOGRAPHIC DATA
  DEMOGRAPHICS - BRIEF
  DEMOGRAPHICS - BRIEF W/ADV DIR
  DEMOGRAPHICS - W/O REMARKS
  DENTAL
  DIAGNOSTIC PROCEDURE
  DIRECTIONS TO PATIENT HOME
  EDUCATIONAL ASSESSMENTT
Enter RETURN to continue or '^' to exit:
```

Figure 4-6: Example output of List Health Summary Components (LC)

4.5 List Measurement Panel Types (LM)

Use the LM option to view a list of the available measurement panels. Both the standard panels distributed with the Health Summary package and any panels that were created at your facility will display. The list is pulled from the B index in HEALTH SUMMARY MEAS PANEL file. Follow these steps:

1. At the “Select Build Health Summary Option” prompt, type **LM** to display a list of measurement panel types.

   The following is a partial list of measurement panel types.

```
Existing HEALTH SUMMARY MEAS PANELS:

  ADULT STD
  ADULT STD METRIC
  PEDIATRIC STD
  PEDIATRIC STD METRIC
  PRENATAL MEAS
Enter RETURN to continue or '^' to exit:
```

Figure 4-7: Example of HEALTH SUMMARY MEAS PANELS (LM)

4.6 List Health Summary Flowsheets (LF)

Use the LF option to display the names of flowsheets that exist at the user's facility. Remember that all flowsheets must be created locally. No flowsheets were distributed with this package. Follow these steps:

- At the "Select Build Health Summary Option" prompt, type **LF** to display a list of existing health summary flowsheets displays.

```
Existing HEALTH SUMMARY FLOWSHEETS:
  ANTICOAGULATION SERVICE
  CARDIOVASCULAR DISEASE
  DIABETIC FLOWSHEET
  EMPLOYEE HEALTH
  KIDNEY CLINIC
  PN HF SCREEN
  PRENATAL FLOWSHEET
Enter RETURN to continue or '^' to exit:
```

Figure 4-8: Example of HEALTH SUMMARY FLOWSHEETS (LF)

4.7 List Health Summary Flowsheet Items (LI)

Use the LI option to list the flowsheet items of a specified flowsheet. Follow the step below:

- At the "Build Health Summary Option" prompt, type **LI** to display existing health summary flowsheet items.

```
Existing HEALTH SUMMARY FLOWSHEET ITEMS:

  EXAMINATION
  HEALTH FACTOR
  LAB RESULT
  MEASUREMENT
  MEDICATION
  PATIENT EDUCATION
  PURPOSE OF VISIT
Enter RETURN to continue or '^' to exit:
```

Figure 4-9: Sample list of HEALTH SUMMARY FLOWSHEET ITEMS (LI)

4.8 Create/Modify Health Summary Type (MS)

Before constructing a new health summary type, carefully outline the details to include in the new summary while keeping in mind its intended purpose and use. For example, decide which components to include, the order in which the components will print, the data restrictions applied to the components, whether any custom measurement panels or flowsheets will be needed, and the name of the Health Summary. This planning step is very important.

A Request for New Health Summary form is provided in Appendix F. You can copy this form and use it to help with the planning process, or fill it out and give the form to a site manager to complete. Follow these steps to create or modify a health summary type:

1. At the “Build Health Summary Option” prompt, type **MS**.
2. At the “Health Summary Type Name” prompt, specify the name of the desired health summary.
3. If a new name was used, the application displays the “Are you adding ‘[summary name]’ as a new HEALTH SUMMARY TYPE? No//” prompt. Type either **Y** (Yes) or **N** (No) and press Enter. N (No) is the default value and will display the “Build Health Summary Option” prompt.
4. At the “Lock” prompt, a security key can be added to the Health Summary. If a security key is added, only users who have the key will be able to modify this health summary type. To use a security key, indicate the name of the key. To bypass the prompt, press Enter.
5. If an existing name was used it will display at the “Name” prompt. If this is correct, press Enter. Otherwise, type ^ (caret) to start over.

The Create/Modify Summary Type screen is shown below.

```
                          ************************************
                          **        IHS Health Summary      **
                          **    Build Health Summary Menu   **
                          ************************************
                                IHS PCC Suite Version 2.0

                                   DEMO HOSPITAL


  IS   Inquire About a Health Summary Type
  PP   Print Health Maintenance Item Protocols
  LS   List Health Summary Types
  LC   List Health Summary Components
  LM   List Measurement Panel Types
  LF   List Health Summary Flowsheets
  LI   List Health Summary Flowsheet Items
  MS   Create/Modify Health Summary Type
  MM   Create/Modify Measurement Panel
  MF   Create/Modify Flowsheet
  HS   Generate Health Summary
  BRHS  Browse Health Summary
  FMMT  Create/Modify Health Summary Type using Fileman
  HSSP  Update Health Summary Site parameters
  PWH  Patient Wellness Handout Menu ...

Select Build Health Summary Option: MS Create/Modify Health Summary Type


This option will allow you to create a new or modify an existing
health summary type.
```

```
Select HEALTH SUMMARY TYPE NAME: TEST
NAME: TEST//
LOCK:


BP  Best Practice PromptsSP  Supplements


Create/Modify Summary Type                  Feb 04, 2010 10:51:22     Page:  1 of  7
Health Summary: TESTING

STRUCTURE:
Order Component                 Max occ Time Alternate Title
5   MEDS - ALL                    1Y
10  MEDS - ALL W/#ISS & ALT NAME           1Y
15  MEDS - ALL WITH # ISSUED             1Y
20  MEDS - CHRONIC                  1Y


+     Enter ?? for more actions
MS  Modify Structure   FS  Flow Sheets     GI  General Info
MP  Mod Meas Panel    HF  Health Factors    HS  Sample Health Summary
LP  Lab Panel      PC  Provider Class Scrn Q  Quit
HM  Health Main Remind  CS  Clinic Screen
BP  Best Practice PromptsSP  Supplements
Select Action: +// /
```

Figure 4-10: Sample Create/Modify Summary Type screen (MS)

- To display the next screen, type a plus sign (+) at the “Select Action” prompt. To display the prior screen, type a minus sign (–).
- To exit the Create/Modify Summary Type screen, type **Q** (Quit) at the “Select Action” prompt and return to the “Select Build Health Summary Option” prompt.
- Otherwise, use any of the following options to create or modify a Health Summary.

4.8.1 Modify Structure (MS)

Use the MS option to add a new component to or remove an existing component from the summary type.

- To add a new component, at the “Select Action” prompt, type **MS** and press Enter.
- At the “Select SUMMARY ORDER” prompt, specify a new order number in which the new component should be placed. Press Enter.
- At the “STRUCTURE COMPONENT NAME” prompt, type the name of the component that should display (e.g., Demographics–Brief). Press Enter.
- At the “COMPONENT NAME” prompt, if the correct name displays as the default, press Enter. If not, type the correct name.

- At the “ALTERNATE TITLE” prompt, type an alternate name of the component. This information is not required. Press Enter.
- At the “Select SUMMARY ORDER” prompt, if all components are added, press Enter. To add another component, repeat the steps above.

In the following example, the Demographics–Brief component is added as the first component in the structure.

```
Create/Modify Summary Type                  Feb 04, 2010 10:53:45     Page:  1 of  7
Health Summary: TESTING

STRUCTURE:
Order Component                 Max occ Time Alternate Title
5   MEDS - ALL                    1Y
10  MEDS - ALL W/#ISS & ALT NAME           1Y
15  MEDS - ALL WITH # ISSUED             1Y
20  MEDS - CHRONIC                  1Y
25  MEDS - CHRONIC & ACUTE W/ ISSUE HISTORY      1Y
30  MEDS - CHRONIC BY NAME              1Y
35  MEDS - CHRONIC EXCLUDING D/C'ED MEDS       1Y
40  MEDS - CURRENT                  1Y
45  MEDS - CURRENT BY NAME              1Y
50  MEDS - MOST RECENT BY GROUP            1Y
55  MEDS - MOST RECENT OF EACH            1Y
60  MEDS - MOST RECENT SHORT FORM           1Y


+     Enter ?? for more actions
MS  Modify Structure   FS  Flow Sheets     GI  General Info
MP  Mod Meas Panel    HF  Health Factors    HS  Sample Health Summary
LP  Lab Panel      PC  Provider Class Scrn Q  Quit
HM  Health Main Remind  CS  Clinic Screen
BP  Best Practice PromptsSP  Supplements

Select Action: +// MS  Modify Structure

You can add a new component by entering a new order number and
component name. To remove a component from this summary type select the
component by name or order and then enter an '@'.

Select SUMMARY ORDER: 100// 3
  STRUCTURE COMPONENT NAME: DEMOGRAPHICS
   1  DEMOGRAPHICS - BRIEF
   2  DEMOGRAPHICS - BRIEF W/ADV DIRECTIVES
   3  DEMOGRAPHICS - W/O REMARKS
CHOOSE 1-3: 1 DEMOGRAPHICS - BRIEF
 COMPONENT NAME: DEMOGRAPHICS - BRIEF//
 ALTERNATE TITLE:
Select SUMMARY ORDER:

BP  Best Practice PromptsSP  Supplements

Create/Modify Summary Type                  Feb 04, 2010 10:54:12     Page:  1 of  7
Health Summary: TESTING

STRUCTURE:
Order Component                 Max occ Time Alternate Title
3   DEMOGRAPHICS - BRIEF
5   MEDS - ALL                    1Y
```

```
10  MEDS - ALL W/#ISS & ALT NAME           1Y
15  MEDS - ALL WITH # ISSUED             1Y
20  MEDS - CHRONIC                  1Y


Select Action: +//
```

Figure 4-11: Example of Modify Structure

- To remove a component from this summary, at the “Select Action” prompt, type **MS** and press Enter.

At the “Select SUMMARY ORDER” prompt:

- If the component to remove is the default option, type the at sign (**@**) and press Enter.
- If the component to remove is not the default option, type the order number of the component to remove and press Enter. At the “SUMMARY ORDER” prompt, which now displays the order number just entered as the default option, type the at sign (**@**) and press Enter.
- At the “SURE YOU WANT TO DELETE THE ENTIRE '[component order #]' SUMMARY ORDER?” prompt, type **Y** (Yes) or **N** (No). Press Enter.
- At the “Select SUMMARY ORDER” prompt, if all the desired components are removed, press Enter. To remove another component, repeat the steps above.
- In the following example, the Demographics–Brief component is removed from the structure.

```
Create Health Summary: TESTING

STRUCTURE:
Order Component                  Max occ Time Alternate Title
3   DEMOGRAPHICS - BRIEF
5   MEDS - ALL                     1Y
10  MEDS - ALL W/#ISS & ALT NAME           1Y
15  MEDS - ALL WITH # ISSUED             1Y
20  MEDS - CHRONIC                  1Y
25  MEDS - CHRONIC & ACUTE W/ ISSUE HISTORY      1Y
30  MEDS - CHRONIC BY NAME              1Y
35  MEDS - CHRONIC EXCLUDING D/C'ED MEDS       1Y
40  MEDS - CURRENT                  1Y
45  MEDS - CURRENT BY NAME              1Y
50  MEDS - MOST RECENT BY GROUP            1Y
55  MEDS - MOST RECENT OF EACH            1Y

+     Enter ?? for more actions
MS  Modify Structure   FS  Flow Sheets     GI  General Info
MP  Mod Meas Panel    HF  Health Factors    HS  Sample Health
Summary
LP  Lab Panel      PC  Provider Class Scrn Q  Quit
HM  Health Main Remind  CS  Clinic Screen
BP  Best Practice PromptsSP  Supplements
```

```
Select Action: +// MS  Modify Structure

You can add a new component by entering a new order number and
component name. To remove a component from this summary type select
the component by name or order and then enter an '@'.

Select SUMMARY ORDER: 3// @
  SURE YOU WANT TO DELETE THE ENTIRE '3' SUMMARY ORDER? Y (Yes)
Select SUMMARY ORDER: 5//
```

Figure 4-12: Example of selecting summary order

4.8.2 Mod Meas Panel (MP)

Use the MP option to add a new measurement panel or remove an existing measurement type from the summary type. When Measurement Panels is specified as a component in the summary type, this field controls the display order of the associated measurement.

> **Note**: Even if measurement panels are added to the Measurement Panels section, the "Measurement Panel" component must be added to or already exist as a component in the Health Summary's structure for the component to actually display in the Health Summary. For instructions on how to add a Measurement Panel as a component in the Health Summary's structure, refer to Section 4.8.1 Modify Structure.

- To add a new measurement panel, at the "Select Action" prompt, type **MP** and press Enter.
- At the "Select MEASUREMENT PANEL SEQUENCE" prompt, specify a new order number in which the new measurement panel should display within the section, and press Enter.
- At the "MEASUREMENT SEQUENCE MEASUREMENT PANEL TYPE" prompt, type the name of the measurement panel that should display (e.g., Adult), and press Enter.
- At the "MEASUREMENT PANEL TYPE" prompt, if the correct name displays as the default, press Enter. If not, type the correct measurement panel name.
- At the "Select MEASUREMENT PANEL SEQUENCE" prompt, if all measurement panels are added, press Enter. To add another component, repeat the steps above.

In the following example, there are no existing Measurement Panel types in the Measurement Panels section. The user adds two new Measurement Panels types: Adult Standard (Std) and Pediatric Standard (Std).

```
Create/Modify Summary Type                  Feb 04, 2010 11:20:51     Page:  2 of  7
Health Summary: TESTING
+
100  BEST PRACTICE PROMPTS

GENERAL:
Clinic Displayed on outpatient components:
ICD Text Display:
Provider Narrative Displayed:
Display Provider Initials in Outpatient components:
Provider Initials displayed on Medication components:

MEASUREMENT PANELS:
<none>

LAB TEST PANELS:
<none>
+     Enter ?? for more actions
MS  Modify Structure   FS  Flow Sheets     GI  General Info
MP  Mod Meas Panel    HF  Health Factors    HS  Sample Health Summary
LP  Lab Panel      PC  Provider Class Scrn Q  Quit
HM  Health Main Remind  CS  Clinic Screen
BP  Best Practice PromptsSP  Supplements

Select Action: +// MP  Mod Meas Panel

WARNING: Measurement Panels has not been added to the Health Summary Structure.
Measurement panels will not display until they are part of the summary
structure.

You can add a new measurement panel by entering a new sequence number
and measurement panel name. The measurement panel must have been added using
the option 'Create/Modify Measurement Panel' in order to be selected.
To remove a measurement panel from this summary type select the measurement
panel by sequence number and type an '@',

Select MEASUREMENT PANEL SEQUENCE: 10
 MEASUREMENT PANEL SEQUENCE MEASUREMENT PANEL TYPE: ADULT STD
 MEASUREMENT PANEL TYPE: ADULT STD//
Select MEASUREMENT PANEL SEQUENCE: 20
  MEASUREMENT PANEL SEQUENCE MEASUREMENT PANEL TYPE: PED
   1  PEDIATRIC STD
   2  PEDIATRIC STD METRIC
CHOOSE 1-2: 1 PEDIATRIC STD
 MEASUREMENT PANEL TYPE: PEDIATRIC STD//
Select MEASUREMENT PANEL SEQUENCE:


BP  Best Practice PromptsSP  Supplements

Create/Modify Summary Type                  Feb 04, 2010 11:21:55     Page:  2 of  7
Health Summary: TESTING
+
100  BEST PRACTICE PROMPTS

GENERAL:
Clinic Displayed on outpatient components:
ICD Text Display:
Provider Narrative Displayed:
Display Provider Initials in Outpatient components:
Provider Initials displayed on Medication components:
```

```
MEASUREMENT PANELS:
Order Panel
10  ADULT STD
20  PEDIATRIC STD

+     Enter ?? for more actions
MS  Modify Structure   FS  Flow Sheets     GI  General Info
MP  Mod Meas Panel    HF  Health Factors    HS  Sample Health Summary
LP  Lab Panel      PC  Provider Class Scrn Q  Quit
HM  Health Main Remind  CS  Clinic Screen
BP  Best Practice PromptsSP  Supplements
Select Action: +//
```

Figure 4-13: Example of MEASUREMENT PANEL SEQUENCE

- To remove a measurement panel from the Measurement Panel section, at the "Select Action" prompt, type **MP** and press Enter.

At the "Select MEASUREMENT PANEL SEQUENCE" prompt:

- If the measurement panel to remove is the default option, type the at sign (**@**) and press Enter.
- If the measurement panel to remove is not the default option, type the order number of the measurement panel to remove and press Enter. At the "MEASUREMENT PANEL SEQUENCE" prompt, which now displays the order number just entered as the default option, type the at sign (**@**) and press Enter.
- At the "SURE YOU WANT TO DELETE THE ENTIRE '[order #]' MEASUREMENT PANEL SEQUENCE?" prompt, type **Y** (Yes) or **N** (No), and press Enter.
- At the "Select MEASUREMENT PANEL" prompt, if all the desired measurement panels are removed, press Enter. To remove another measurement panel, repeat the steps above.

In the following example, the Adult Standard measurement panel is removed.

```
Create/Modify Summary Type                  Feb 04, 2010 11:36:46     Page:  2 of  7
Health Summary: TESTING
+
100  BEST PRACTICE PROMPTS

GENERAL:
Clinic Displayed on outpatient components:
ICD Text Display:
Provider Narrative Displayed:
Display Provider Initials in Outpatient components:
Provider Initials displayed on Medication components:

MEASUREMENT PANELS:
Order Panel
10  ADULT STD
20  PEDIATRIC STD

+     Enter ?? for more actions
```

```
MS  Modify Structure   FS  Flow Sheets     GI  General Info
MP  Mod Meas Panel    HF  Health Factors    HS  Sample Health Summary
LP  Lab Panel      PC  Provider Class Scrn Q  Quit
HM  Health Main Remind  CS  Clinic Screen
BP  Best Practice PromptsSP  Supplements

Select Action: +// MP  Mod Meas Panel

WARNING: Measurement Panels has not been added to the Health Summary Structure.
Measurement panels will not display until they are part of the summary
structure.

You can add a new measurement panel by entering a new sequence number
and measurement panel name. The measurement panel must have been added using
the option 'Create/Modify Measurement Panel' in order to be selected.
To remove a measurement panel from this summary type select the measurement
panel by sequence number and type an '@',

Select MEASUREMENT PANEL SEQUENCE: 20// 10    ADULT STD
 MEASUREMENT PANEL SEQUENCE: 10// @
  SURE YOU WANT TO DELETE THE ENTIRE '10' MEASUREMENT PANEL SEQUENCE? Y (Yes)
Select MEASUREMENT PANEL SEQUENCE:



BP  Best Practice PromptsSP  Supplements

Create/Modify Summary Type  Feb 04, 2010 11:37:08     Page:  2 of  7
Health Summary: TESTING
+
100  BEST PRACTICE PROMPTS

GENERAL:
Clinic Displayed on outpatient components:
ICD Text Display:
Provider Narrative Displayed:
Display Provider Initials in Outpatient components:
Provider Initials displayed on Medication components:

MEASUREMENT PANELS:
Order Panel
20  PEDIATRIC STD

LAB TEST PANELS:
+     Enter ?? for more actions
MS  Modify Structure   FS  Flow Sheets     GI  General Info
MP  Mod Meas Panel    HF  Health Factors    HS  Sample Health Summary
LP  Lab Panel      PC  Provider Class Scrn Q  Quit
HM  Health Main Remind  CS  Clinic Screen
BP  Best Practice PromptsSP  Supplements
Select Action: +//
```

Figure 4-14: Example of removal of the Adult Standard Measurement Panel

4.8.3 Lab Panel (LP)

- Use the LP option to add a new laboratory test or remove an existing laboratory test from the summary type.

> **Note**: Even if lab panels are added to the Lab Panels section, the "Lab Panels" component must be added to or already exist as a component in the Health Summary's structure for the component to actually display in the Health Summary. For instructions on how to add Lab Panels as a component in the Health Summary's structure, refer to Section 4.8.1 Modify Structure.

- To add a new measurement panel, at the "Select Action" prompt, type **LP** and press Enter.
- At the "Select LAB TEST SEQUENCE" prompt, specify a new order number in which the new lab panel should display within the section and press Enter.
- At the "LAB TEST PANEL LAB TEST TYPE" prompt, type the name of the lab panel that should display (e.g., Lymphs) and press Enter.
- At the "LAB TEST TYPE" prompt, if the correct name displays as the default, press Enter. If not, type the correct measurement panel name.
- At the "Select LAB TEST SEQUENCE" prompt, if all measurement panels are added, press Enter. To add another component, repeat the steps above.
- In the following example, there are no existing laboratory test panel types in the Lab Test Panels section. The user adds one new lab panel, Lymphs.

```
Create/Modify Summary Type                  Feb 04, 2010 11:43:24     Page:  3 of  7
Health Summary: TESTING

LAB TEST PANELS
<none>

HEALTH MAINTENANCE REMINDERS:
<none>


+     Enter ?? for more actions
MS  Modify Structure   FS  Flow Sheets     GI  General Info
MP  Mod Meas Panel    HF  Health Factors    HS  Sample Health Summary
LP  Lab Panel      PC  Provider Class Scrn Q  Quit
HM  Health Main Remind  CS  Clinic Screen
BP  Best Practice PromptsSP  Supplements

Select Action: +// LP  Lab Panel

WARNING: LABORATORY DATA has not been added to the Health Summary Structure.
The LABS you put on the panel will not display until LABORATORY DATA is a part
of the summary structure.

You can add a new LAB TEST by entering a new sequence number and
the LAB TEST name. To remove a LAB TEST from this summary type select the
LAB TEST by name or sequence number and then enter an '@'.

Select LAB TEST SEQUENCE: 10
  LAB TEST PANEL LAB TEST TYPE: LYMPHS
 LAB TEST TYPE: LYMPHS//
```

```
Select LAB TEST SEQUENCE:


BP  Best Practice PromptsSP  Supplements

Create/Modify Summary Type  Feb 04, 2010 11:43:49     Page:  3 of  7
Health Summary: TESTING

LAB TEST PANELS
10  LYMPHS

HEALTH MAINTENANCE REMINDERS:
<none>

+     Enter ?? for more actions
MS  Modify Structure   FS  Flow Sheets     GI  General Info

MP  Mod Meas Panel    HF  Health Factors    HS  Sample Health Summary
LP  Lab Panel      PC  Provider Class Scrn Q  Quit
HM  Health Main Remind  CS  Clinic Screen
BP  Best Practice PromptsSP  Supplements
Select Action: +//
```

Figure 4-15: Example of adding a new Lab Panel called “Lymphs”

- To remove a lab panel from the Lab Panel section, at the “Select Action” prompt, type **LP** and press Enter.

At the “Select LAB TEST SEQUENCE” prompt:

- If the lab panel to remove is the default option, type the at sign (**@**) and press Enter.
- If the lab panel to remove is not the default option, type the order number of the measurement panel to remove and press Enter. At the “LAB TEST SEQUENCE” prompt, which now displays the order number just entered as the default option, type the at sign (**@**) and press Enter.
- At the “SURE YOU WANT TO DELETE THE ENTIRE '[order #]' LAB TEST SEQUENCE?” prompt, type **Y** (Yes) or **N** (No) and press Enter.
- At the “Select LAB TEST SEQUENCE” prompt, if all the desired lab test panels are removed, press Enter. To remove another laboratory test panel, repeat the steps above.
- In the following example, the Lymphs lab test panel is removed.

```
Create/Modify Summary Type                  Feb 04, 2010 11:43:49     Page:  3 of  7
Health Summary: TESTING

LAB TEST PANELS
10  LYMPHS

HEALTH MAINTENANCE REMINDERS:
<none>

+     Enter ?? for more actions
```

```
MS  Modify Structure   FS  Flow Sheets     GI  General Info
MP  Mod Meas Panel    HF  Health Factors    HS  Sample Health Summary
LP  Lab Panel      PC  Provider Class Scrn Q  Quit
HM  Health Main Remind  CS  Clinic Screen
BP  Best Practice PromptsSP  Supplements
Select Action: +// LP  Lab Panel

WARNING: LABORATORY DATA has not been added to the Health Summary Structure.
The LABS you put on the panel will not display until LABORATORY DATA is a part
of the summary structure.

You can add a new LAB TEST by entering a new sequence number and
the LAB TEST name. To remove a LAB TEST from this summary type select the
LAB TEST by name or sequence number and then enter an '@'.



Select LAB TEST SEQUENCE: 10// @
  SURE YOU WANT TO DELETE THE ENTIRE '10' LAB TEST SEQUENCE? Y (Yes)

Select LAB TEST SEQUENCE:

Create/Modify Summary Type                  Feb 04, 2010 11:43:49     Page:  3 of  7
Health Summary: TESTING
LAB TEST PANELS
<none>

HEALTH MAINTENANCE REMINDERS:
<none>

+     Enter ?? for more actions
MS  Modify Structure   FS  Flow Sheets     GI  General Info
MP  Mod Meas Panel    HF  Health Factors    HS  Sample Health Summary
LP  Lab Panel      PC  Provider Class Scrn Q  Quit
HM  Health Main Remind  CS  Clinic Screen
BP  Best Practice PromptsSP  Supplements
Select Action: +//
```

Figure 4-16: Example of removing a LAB TEST Panel

4.8.4 Health Main Reminder (HM)

Use the HM option to list currently defined health maintenance reminders for the selected summary type. See the following example.

```
Configure HMR's for a Summary                  Dec 15, 2008 10:39:16   Page: 1 of 4
Health Summary: XXX3

Note: any reminder flagged as inactive will not display on the summary even though
you selected it for display. The reminder must be activated. Any reminders with
(DEL) should be removed as they are no longer used.

Currently defined HEALTH MAINTENANCE REMINDERS on the SJT3 summary type SEQ Health
Maintenance Reminder Category/Group
-------------------------------------------------------------------

Other REMINDERS not yet selected that can be added to this summary type
  BREAST EXAM      GENERAL
  DIABETES SCREENING    GENERAL
```

```
  BLOOD PRESSURE     GENERAL
  PAP SMEAR      CANCER-RELATED
  RECTAL       CANCER-RELATED
  TONOMETRY      ELDER
  URINALYSIS      PEDIATRIC
  PELVIC EXAM      GENERAL
  VISUAL ACUITY EXAM    ELDER
  HEARING TEST      PEDIATRIC
  HCT/HGB       PEDIATRIC
  NON-ENDEMIC TB     GENERAL
  HEAD CIRCUMFERENCE    PEDIATRIC
  HEIGHT       GENERAL
  WEIGHT       GENERAL
  IMMUNIZATIONS     IMMUNIZATIONS
  MAMMOGRAM      CANCER-RELATED
  PNEUMOVAX      IMMUNIZATIONS

  ALCOHOL USE SCREENING   BEHAVIORAL HEALT
  TOBACCO USE SCREENING   CANCER-RELATED
+   Enter ?? for more actions
AR Add Reminder to Summary RG Remove all Reminders in a Group
RI Remove Individual Reminder HS Sample Health Summary
AG Add a Group of Reminders Q Quit
Select Action: +//
```

Figure 4-17: Example Health Main Reminder screen (HM)

- At the “Select Action” prompt using the AR and RI options will either add or remove a reminder to the summary.
- The AG and RG options add/remove reminders in a group. Select a category of reminder, such as Asthma.
- The HS option displays the Health Summary of a specific patient.
- Type **Q** at the “Select Action” prompt to exit the current screen and return to the “Select Build Health Summary” prompt.

4.8.5 Best Practice Prompts (BP)

Use the BP option to list Best Practice Prompts for the selected summary type.

```
Configure TPs for a Summary                          Dec 15, 2008 11:53 Page: 1 of 2
Health Summary: CHR

Note: Any Best Practice Prompt flagged as inactive will not display on the summary
even though the user selected it for display. The Best Practice Prompt must be
activated. Any Best Practice Prompts with (DEL) should be removed as they are no
longer used.

Currently defined BEST PRACTICE PROMPTS on the CHR summary type SEQ Best Practice
Prompts Category/Group
-------------------------------------------------------------------


Other BEST PRACTICE PROMPTS not yet selected that can be added to this summary type:
HEARING INQUIRY           ELDER
```

```
STRABISMUS/AMBLYOPIA SCREEN        PEDIATRIC
ASTHMA: ADD/INCREASE INHALED STEROIDS      ASTHMA
ASTHMA: PRIMARY CARE PROVIDER        ASTHMA
ASTHMA: SEVERITY CLASSIFICATION       ASTHMA
ASTHMA: ACTION PLAN          ASTHMA
ASTHMA: FLU SHOT           ASTHMA
ASTHMA: CONTROL CLASSIFICATION       ASTHMA
ASTHMA: INCREASED RISK FOR EXACERBATION     ASTHMA

Enter ?? for more actions
AR Add Best Practice Prompt  RG Remove Group of Best Pract Prompts
RI Remove Best Practice Prompt HS Sample Health Summary
AG Add Group of Best Pract Prompts Q Quit
Select Action:+//
```

Figure 4-18: Example BEST PRACTICE PROMPTS screen (BP)

- Type **AR** and **RI** to add or remove a Best Practice prompt.
- Type **AG** and **RG** to add or remove a group of Best Practice prompts.
- Type **Q** (Quit) at the "Select Action" prompt to leave the Best Practice Prompt screen and return to the **"**Build Health Summary Option" prompt.

4.8.6 Flow Sheets (FS)

Use the FS option to add a new flowsheet or remove an existing flowsheet from the summary type.

> **Note**: Even if flowsheets are added to the Flowsheet section, the "Flowsheet" component must be added to or already exist as a component in the Health Summary's structure for the component to actually display in the Health Summary. For instructions on how to add Flowsheet as a component in the Health Summary's structure, refer to Section 4.8.1 Modify Structure.

- To add a new flowsheet, at the "Select Action" prompt, type **LP** and press Enter.
- At the "Select FLOWSHEET SEQUENCE" prompt, specify a new order number in which the new flowsheet should display within the section and press Enter.
- At the "FLOWSHEET SEQUENCE FLOWSHEET TYPE" prompt, type the name of the flowsheet that should display (e.g., Diabetic) and press Enter.
- At the "FLOWSHEET TYPE" prompt, if the correct name displays as the default, press Enter. If not, type the correct measurement panel name.
- At the "Select FLOWSHEET SEQUENCE" prompt, if all desired flowsheets are added, press Enter. To add another flowsheet, repeat the steps above.
- In the following example, there are no existing flowsheet types in the Flowsheets section. The user adds one new laboratory panel, Diabetic Flowsheet.

```
Create/Modify Summary Type                  Feb 04, 2010 11:43:24     Page:  3 of  7
Health Summary: TESTING

FLOWSHEET
<none>

HEALTH FACTORS:
<none>


+     Enter ?? for more actions
MS  Modify Structure   FS  Flow Sheets     GI  General Info
MP  Mod Meas Panel    HF  Health Factors    HS  Sample Health Summary
LP  Lab Panel      PC  Provider Class Scrn Q  Quit
HM  Health Main Remind  CS  Clinic Screen
BP  Best Practice PromptsSP  Supplements


Select Action: +// FS  Flow Sheets

WARNING: FLOWSHEETS has not been added to the Health Summary Structure.
FLOWSHEETS will not display until they are part of the summary
structure.

You can add a new FLOWSHEET by entering a new sequence number
and FLOWSHEET name. The FLOWSHEET must have been added using
the option 'Create/Modify Flowsheet' in order to be selected.
To remove a FLOWSHEET from this summary type select the FLOWSHEET
by sequence number and type an '@',

  FLOWSHEET SEQUENCE FLOWSHEET TYPE: DIABETIC FLOWSHEET
 FLOWSHEET TYPE: DIABETIC FLOWSHEET//
Select FLOWSHEET SEQUENCE:


BP  Best Practice PromptsSP  Supplements

Create/Modify Summary Type                  Feb 04, 2010 12:09:29     Page:  7 of  7
Health Summary: TESTING
+
FLOWSHEET:
Order Flowsheet
10  DIABETIC FLOWSHEET

HEALTH FACTORS:
<none>

Provider Class Screen for OUTPATIENT VISITS (SCREENED) component (IF USED):

CLINIC Screen for OUTPATIENT VISITS (SCREENED) component (IF USED):

     Enter ?? for more actions
MS  Modify Structure   FS  Flow Sheets     GI  General Info
MP  Mod Meas Panel    HF  Health Factors    HS  Sample Health Summary
LP  Lab Panel      PC  Provider Class Scrn Q  Quit
HM  Health Main Remind  CS  Clinic Screen
BP  Best Practice PromptsSP  Supplements

Select Action: +//
```

Figure 4-19: Example of adding a Flowsheet

- To remove a flowsheet from the Flowsheet section, at the “Select Action” prompt, type **FS** and press Enter.

At the “Select FLOWSHEET SEQUENCE” prompt:

- If the flowsheet to remove is the default option, type the at sign (**@**) and press Enter.
- If the flowsheet to remove is not the default option, type the order number of the flowsheet and press Enter. At the “FLOWSHEET SEQUENCE” prompt, which now displays the order number just entered as the default option, type the at sign (**@**) and press Enter.
- At the “SURE YOU WANT TO DELETE THE ENTIRE '[order #]' FLOWSHEET SEQUENCE?” prompt, type **Y** (Yes) or **N** (No), and press Enter.
- At the “Select FLOWSHEET SEQUENCE” prompt, if all the desired flowsheets are removed, press Enter. To remove another flowsheet, repeat the steps above.

In the following example, Diabetic Flowsheet is removed.

```
Create/Modify Summary Type                  Feb 04, 2010 11:43:49     Page:  3 of  7
Health Summary: TESTING

FLOWSHEET:
Order Flowsheet
10  DIABETIC FLOWSHEET

HEALTH FACTORS:
<none>


+     Enter ?? for more actions
MS  Modify Structure   FS  Flow Sheets     GI  General Info
MP  Mod Meas Panel    HF  Health Factors    HS  Sample Health Summary
LP  Lab Panel      PC  Provider Class Scrn Q  Quit
HM  Health Main Remind  CS  Clinic Screen
BP  Best Practice PromptsSP  Supplements

Select Action: +// FS  Flow Sheets

WARNING: FLOWSHEETS has not been added to the Health Summary Structure.
FLOWSHEETS will not display until they are part of the summary
structure.

You can add a new FLOWSHEET by entering a new sequence number
and FLOWSHEET name. The FLOWSHEET must have been added using
the option 'Create/Modify Flowsheet' in order to be selected.
To remove a FLOWSHEET from this summary type select the FLOWSHEET
by sequence number and type an '@',

Select FLOWSHEET SEQUENCE: 10// @
  SURE YOU WANT TO DELETE THE ENTIRE '10' FLOWSHEET SEQUENCE? Y (Yes)
Select FLOWSHEET SEQUENCE:

BP  Best Practice Prompts SP  Supplements

………….…
```

```
Create/Modify Summary Type                 Feb 04, 2010 12:09:29     Page:  7 of  7
Health Summary: TESTING
+
FLOWSHEET:
<none>

HEALTH FACTORS:
<none>

Provider Class Screen for OUTPATIENT VISITS (SCREENED) component (IF USED):

CLINIC Screen for OUTPATIENT VISITS (SCREENED) component (IF USED):

     Enter ?? for more actions
MS  Modify Structure   FS  Flow Sheets     GI  General Info
MP  Mod Meas Panel    HF  Health Factors    HS  Sample Health Summary
LP  Lab Panel      PC  Provider Class Scrn Q  Quit
HM  Health Main Remind  CS  Clinic Screen
BP  Best Practice PromptsSP  Supplements

Select Action: +//
```

Figure 4-20: Example of removing a Flowsheet

4.8.7 Health Factors (HF)

Use the HF option to add a new health factor or remove an existing health factor from the summary type.

> **Note**: Even if health factors are added to the Health Factors section, the "Health Factors" component must be added to or already exist as a component in the Health Summary's structure for the component to actually display in the Health Summary. For instructions on how to add Health Factors as a component in the Health Summary's structure, refer to Section 4.8.1 Modify Structure.

- To add a new health factor, at the "Select Action" prompt, type **HF** and press Enter.
- At the "Select HEALTH FACTOR SEQUENCE" prompt, specify a new order number in which the new health factor should display within the section. Press Enter.
- At the "HEALTH FACTOR TITLE" prompt, enter an alternate title for the health factor display. This is not a required field.
- At the "DISPLAY MOST RECENT INSTANCE" prompt, type **Y** (Yes) to display the most recent only, type **N** (No) to display all occurrences.
- At the "Select HEALTH FACTOR SEQUENCE" prompt, if all desired health factors are added, press Enter. To add another, repeat the steps above.

- In the following example, there are no existing health factors in the Health Factors section. The user adds one new health factor, Asthma.

```
Create/Modify Summary Type                  Feb 04, 2010 11:43:24     Page:  3 of  7
Health Summary: TESTING

FLOWSHEET
<none>

HEALTH FACTORS:
<none>

+     Enter ?? for more actions


MS  Modify Structure   FS  Flow Sheets     GI  General Info
MP  Mod Meas Panel    HF  Health Factors    HS  Sample Health Summary
LP  Lab Panel      PC  Provider Class Scrn Q  Quit
HM  Health Main Remind  CS  Clinic Screen
BP  Best Practice PromptsSP  Supplements

Select Action: +// HF  Health Factors

WARNING: HEALTH FACTORS has not been added to the Health Summary Structure.
HEALTH FACTORS will not display until they are part of the summary
structure.
If you want all HEALTH FACTOR categories to display on your summary
then DO NOT update this field. If it is left blank then all HEALTH FACTOR
categories will display. If you want only selected HEALTH FACTOR categories
to display on this summary type then enter them into this field.

You can add a new HEALTH FACTOR category by entering a new sequence number
and HEALTH FACTOR category name.
To remove a HEALTH FACTOR category from this summary type select the category
by sequence number and type an '@',

Select HEALTH FACTOR SEQUENCE: 10
  HEALTH FACTOR SEQUENCE HEALTH FACTOR TYPE: ASTHMA TRIGGERS    ASTHMA TRIGG
ERS
 HEALTH FACTOR TYPE: ASTHMA TRIGGERS//
 HEALTH FACTOR TITLE:
 DISPLAY MOST RECENT INSTANCE: ??
    This field controls whether all instances or only the most recent instance
    of each health factor type within the category will be displayed. For
    example, if MOST RECENT ONLY DISPLAYED is selected for the category of
    TOBACCO USE, the the most recent instance of recording for factors in
    that category, e.g., CURRENT SMOKELESS, CURRENT SMOKER, etc. is displayed.
    Otherwise, ALL instances are shown (which may result because a patient
    has moved repeatedly from one status to another).

   Choose from:
    Y    MOST RECENT ONLY DISPLAYED
    N    ALL OCCURRENCES DISPLAYED
 DISPLAY MOST RECENT INSTANCE: Y MOST RECENT ONLY DISPLAYED
Select HEALTH FACTOR SEQUENCE:



BP  Best Practice PromptsSP  Supplements

Create/Modify Summary Type                Feb 04, 2010 12:21:37     Page:  7 of  7
```

```
Health Summary: TESTING
+
FLOWSHEET:
<none>

HEALTH FACTORS:
Order Health Factor                Title        Most Recent
10  ASTHMA TRIGGERS                         MOST RECENT

SUPPLEMENTS:
<none>

Provider Class Screen for OUTPATIENT VISITS (SCREENED) component (IF USED):

CLINIC Screen for OUTPATIENT VISITS (SCREENED) component (IF USED):

     Enter ?? for more actions

MS  Modify Structure   FS  Flow Sheets     GI  General Info
MP  Mod Meas Panel    HF  Health Factors    HS  Sample Health Summary
LP  Lab Panel      PC  Provider Class Scrn Q  Quit
HM  Health Main Remind  CS  Clinic Screen
BP  Best Practice PromptsSP  Supplements
Select Action: +//
```

Figure 4-21: Example of adding a new HEALTH FACTOR

- To remove a health factor from the Health Factors section, at the “Select Action” prompt, type **HF** and press Enter.
- At the “Select HEALTH FACTORS SEQUENCE” prompt:
  - If the health factor to be removed is the default, type the at sign (**@**) and press Enter.
  - If the health factor to be removed is not the default, type the order number of the health factor to remove and press Enter. At the “FLOWSHEET SEQUENCE” prompt, which now displays the order number just entered as the default option, type the at sign (**@**) and press Enter.
- At the “SURE YOU WANT TO DELETE THE ENTIRE '[order #]' HEALTH FACTOR SEQUENCE?” prompt, type **Y** (Yes) or **N** (No) and press Enter.
- At the “Select HEALTH FACTOR SEQUENCE” prompt, if all the desired health factors are removed, press Enter. To remove another flowsheet, repeat the steps above.

In the following example, Asthma Triggers is removed.

```
Create/Modify Summary Type                  Feb 04, 2010 11:43:49     Page:  3 of  7
Health Summary: TESTING

FLOWSHEET:
Order Flowsheet
10  DIABETIC FLOWSHEET

HEALTH FACTORS:
```

```
Order Health Factor               Title        Most Recent
10  ASTHMA TRIGGERS                         MOST RECENT

+     Enter ?? for more actions
MS  Modify Structure   FS  Flow Sheets     GI  General Info
MP  Mod Meas Panel    HF  Health Factors    HS  Sample Health Summary
LP  Lab Panel      PC  Provider Class Scrn Q  Quit
HM  Health Main Remind  CS  Clinic Screen
BP  Best Practice PromptsSP  Supplements

Select Action: +// HF  Health Factors

WARNING: HEALTH FACTORS has not been added to the Health Summary Structure.
HEALTH FACTORS will not display until they are part of the summary
structure.

If you want all HEALTH FACTOR categories to display on your summary

then DO NOT update this field. If it is left blank then all HEALTH FACTOR
categories will display. If you want only selected HEALTH FACTOR categories
to display on this summary type then enter them into this field.
You can add a new HEALTH FACTOR category by entering a new sequence number
and HEALTH FACTOR category name.
To remove a HEALTH FACTOR category from this summary type select the category
by sequence number and type an '@',

Select HEALTH FACTOR SEQUENCE: 10// @
  SURE YOU WANT TO DELETE THE ENTIRE '10' HEALTH FACTOR SEQUENCE? Y (Yes)
Select HEALTH FACTOR SEQUENCE:


BP  Best Practice PromptsSP  Supplements

Create/Modify Summary Type                 Feb 04, 2010 12:09:29     Page:  7 of  7
Health Summary: TESTING
+
FLOWSHEET:
<none>

HEALTH FACTORS:
<none>

Provider Class Screen for OUTPATIENT VISITS (SCREENED) component (IF USED):

CLINIC Screen for OUTPATIENT VISITS (SCREENED) component (IF USED):

     Enter ?? for more actions
MS  Modify Structure   FS  Flow Sheets     GI  General Info
MP  Mod Meas Panel    HF  Health Factors    HS  Sample Health Summary
LP  Lab Panel      PC  Provider Class Scrn Q  Quit
HM  Health Main Remind  CS  Clinic Screen
BP  Best Practice PromptsSP  Supplements
Select Action: +//
```

Figure 4-22: Example of removing a HEALTH FACTOR SEQUENCE

4.8.8 Provider Class Scrn (PC)

Use the PC option to add a new provider class or remove a provider class from the summary type. This field is used to screen out certain provider disciplines (classes) from the Outpatient Visits (Screened) component.

> **Note**: If the Outpatient Visits Screened component has not been added to the Health Summary structure, the following warning will display: "WARNING: OUTPATIENT VISITS SCREENED has not been added to the Health Summary structure. Entering Provider class values into this field will have no effect unless OUTPATIENT VISITS (SCREENED) is added to the structure." For instructions on how to add Outpatient Visits Screened as a component in the Health Summary's structure, refer to Section 4.8.1 Modify Structure.

If the primary provider for a visit has a provider class that matches a class typed into this field, the visit will not display in the summary in the Outpatient Visits (Screened) section.

- To add a new provider class, at the "Select Action" prompt, type **PC** and press Enter.
- At the "Select PROVIDER CLASSSCREEN" prompt, specify the type of provider class to add, and press Enter. To view a list of all classes, type two question marks (**??**) and press Enter to view the list (example of truncated list in the screen capture below).
- At the "Are you adding'[class]' as a new PROVIDER CLASS SCREEN (THE [#] for this HEALTH SUMMARY TYPE)? No//" prompt, type **Y** (Yes) and press Enter to add a new provider class to the Health Summary. Type **N** (No) and press Enter to not add a new provider class.
- At the "Select PROVIDER CLASS SCREEN" prompt, if all desired classes are added, press Enter. To add another provider class, repeat the steps above.

In the following example, the user adds one new class, PHN/AIDES.

```
Create/Modify Summary Type                  Feb 09, 2010 11:50:24     Page:  1 of  7
Health Summary: TESTING

STRUCTURE:
Order Component                 Max occ Time Alternate Title
5   MEDS - ALL                    1Y
10  MEDS - ALL W/#ISS & ALT NAME           1Y
15  MEDS - ALL WITH # ISSUED             1Y
…

MS  Modify Structure   FS  Flow Sheets     GI  General Info
MP  Mod Meas Panel    HF  Health Factors    HS  Sample Health Summary
```

```
LP  Lab Panel      PC  Provider Class Scrn Q  Quit
HM  Health Main Remind  CS  Clinic Screen
BP  Best Practice PromptsSP  Supplements

Select Action: +// PC  Provider Class Scrn

WARNING: OUTPATIENT VISITS SCREENED has not been added to the Health Summary
structure. Entering Provider class values into this field will have no affect
unless OUTPATIENT VISITS (SCREENED) is added to the structure.


If the primary provider on a visit has a provider class that matches one entered
into this field the visit will NOT display on the summary
in the OUTPATIENT VISITS (SCREENED) section.

To remove a provider class from being screened out of this summary
type the provider class code and type an '@',

Select PROVIDER CLASS SCREEN: ??
    You may enter a new PROVIDER CLASS SCREEN, if you wish
    This field is used to screen out certain provider disciplines (classes)
    from the component called OUTPATIENT VISITS (SCREENS).


  Choose from:

  ACUPUNCTURIST
  ADMINISTRATION
  ALCOHOLISM/SUB ABUSE COUNSELOR
  AMBULANCE DRIVER
  ANESTHESIOLOGIST
  AUDIOLOGIST


Select PROVIDER CLASS SCREEN: PHN
   1  PHN DRIVER/INTERPRETER
   2  PHN/AIDES
CHOOSE 1-2: 2 PHN/AIDES
 Are you adding 'PHN/AIDES' as a new PROVIDER CLASS SCREEN (the 1ST for this HE
ALTH SUMMARY TYPE)? No// Y (Yes)

Select PROVIDER CLASS SCREEN:


Create/Modify Summary Type                  Feb 09, 2010 11:51:13     Page:  7 of  7
Health Summary: TESTING
+
FLOWSHEET:
<none>

HEALTH FACTORS:
<none>

SUPPLEMENTS:
<none>

Provider Class Screen for OUTPATIENT VISITS (SCREENED) component (IF USED):
Provider Classes to be EXCLUDED
PHN/AIDES

CLINIC Screen for OUTPATIENT VISITS (SCREENED) component (IF USED):
```

```
     Enter ?? for more actions

MS  Modify Structure   FS  Flow Sheets     GI  General Info
MP  Mod Meas Panel    HF  Health Factors    HS  Sample Health Summary
LP  Lab Panel      PC  Provider Class Scrn Q  Quit
HM  Health Main Remind  CS  Clinic Screen
BP  Best Practice PromptsSP  Supplements

Select Action: +//
```

Figure 4-23: Example of adding a new provider class

- To remove a provider class, at the “Select Action” prompt, type **PC** and press Enter.

At the “Select PROVIDER CLASS SCREEN” prompt:

- If the class to be removed is the default, type the at sign (**@**) and press Enter.
- If the class to be removed is not the default, type the order number of the class to remove and press Enter.
- At the “SURE YOU WANT TO DELETE?” prompt, type **Y** (Yes) or **N** (No), and press Enter.
- At the “Select PROVIDER CLASS SCREEN” prompt, if all the desired classes are removed, press Enter. To remove another provider class, repeat the steps above.

In the following example, PHN/AIDES is removed.

```
Create/Modify Summary Type                  Feb 09, 2010 12:05:29     Page:  7 of  7
Health Summary: TESTING
+
FLOWSHEET:
<none>

HEALTH FACTORS:
<none>

SUPPLEMENTS:
<none>
Provider Class Screen for OUTPATIENT VISITS (SCREENED) component (IF USED):
Provider Classes to be EXCLUDED
PHN/AIDES

CLINIC Screen for OUTPATIENT VISITS (SCREENED) component (IF USED):
     Enter ?? for more actions
MS  Modify Structure   FS  Flow Sheets     GI  General Info
MP  Mod Meas Panel    HF  Health Factors    HS  Sample Health Summary
LP  Lab Panel      PC  Provider Class Scrn Q  Quit
HM  Health Main Remind  CS  Clinic Screen
BP  Best Practice PromptsSP  Supplements

Select Action: +// PC  Provider Class Scrn
WARNING: OUTPATIENT VISITS SCREENED has not been added to the Health Summary
structure. Entering Provider class values into this field will have no affect
```

```
unless OUTPATIENT VISITS (SCREENED) is added to the structure.

If the primary provider on a visit has a provider class that matches one entered
into this field the visit will NOT display on the summary
in the OUTPATIENT VISITS (SCREENED) section.

To remove a provider class from being screened out of this summary
type the provider class code and type an '@',

Select PROVIDER CLASS SCREEN: PHN/AIDES// @
  SURE YOU WANT TO DELETE? Y (Yes)
Select PROVIDER CLASS SCREEN:
```

Figure 4-24: Example of removing a provider class

4.8.9 Clinic Screen (CS)

Use the CS option to add a new Clinic Screen. This field is used to screen out certain clinic types from the Outpatient Visits (Screened) component.

> **Note**: If the Outpatient Visits Screened component has not been added to the Health Summary structure, the following warning will display: "WARNING: OUTPATIENT VISITS SCREENED has not been added to the Health Summary structure. Entering clinic values into this field will have no effect unless OUTPATIENT VISITS (SCREENED) is added to the structure." For instructions on how to add Outpatient Visits as a component in the Health Summary's structure, refer to Section 4.8.1 Modify Structure.

- To add a new clinic screen, at the "Select Action" prompt, type **CS** and press Enter.
- At the "Select CLINIC SCREEN" prompt, specify the type of clinic screen to add, and press Enter. To view a list of all classes, type two question marks (**??**) and press Enter to view the list (example of truncated list in the screen capture below).
- At the "Are you adding'[clinic]' as a new CLINIC SCREEN (THE [#] for this HEALTH SUMMARY TYPE)? No//" prompt, type **Y** (Yes) and press Enter to add it to the Health Summary. Type **N** (No) and press Enter to not add it.
- At the "Select CLINIC SCREEN" prompt, if all desired clinics are added, press Enter. To add another, repeat the steps above.

In the following example, the user adds one new class, CANCER CHEMOTHERAPY.

```
Create/Modify Summary Type                  Feb 09, 2010 12:10:40     Page:  7 of  7
Health Summary: TESTING
```

```
+
FLOWSHEET:
<none>

HEALTH FACTORS:
<none>

SUPPLEMENTS:
<none>

Provider Class Screen for OUTPATIENT VISITS (SCREENED) component (IF USED):

CLINIC Screen for OUTPATIENT VISITS (SCREENED) component (IF USED):


     Enter ?? for more actions
MS  Modify Structure   FS  Flow Sheets     GI  General Info
MP  Mod Meas Panel    HF  Health Factors    HS  Sample Health Summary
LP  Lab Panel      PC  Provider Class Scrn Q  Quit
HM  Health Main Remind  CS  Clinic Screen
BP  Best Practice PromptsSP  Supplements
Select Action: +// CS  Clinic Screen


WARNING: OUTPATIENT VISITS SCREENED has not been added to the Health Summary
structure. Entering clinic values into this field will have no affect
unless OUTPATIENT VISITS (SCREENED) is added to the structure.

If the clinic of a visit is a clinic that matches one entered
into this field the visit will NOT display on the summary
in the OUTPATIENT VISITS (SCREENED) section.

To remove a clinic from being screened out of this summary
type the clinic code or name and type an '@',

Select CLINIC SCREEN: ??
    You may enter a new CLINIC SCREEN, if you wish
    This field is used to screen out certain clinic types from the component
    called OUTPATIENT VISITS (SCREENED).


  Choose from:
  ALCOHOL AND SUBSTANCE    43
  AMBULANCE    A3
  ANESTHESIOLOGY    D4
  ANTICOAGULATION THERAPY    D1
  AUDIOLOGY    35
  BEHAVIORAL HEALTH    C4
  CANCER CHEMOTHERAPY    62
  CANCER SCREENING    58


Select CLINIC SCREEN: CANCER
   1  CANCER CHEMOTHERAPY    62
   2  CANCER SCREENING    58
CHOOSE 1-2: 1 CANCER CHEMOTHERAPY   62
 Are you adding 'CANCER CHEMOTHERAPY' as a new CLINIC SCREEN (the 1ST for this
HEALTH SUMMARY TYPE)? No// Y (Yes)
Select CLINIC SCREEN:
```

Figure 4-25: Example of adding a new CLINIC SCREEN

- To remove a provider class, at the “Select Action” prompt, type **PC** and press Enter.

At the “Select CLINIC SCREEN” prompt:

- If the clinic to remove is the default option, type the at sign (**@**) and press Enter.
- If the clinic to remove is not the default option, type the order number of the clinic to remove and press Enter.
- At the “SURE YOU WANT TO DELETE?” prompt, type **Y** (Yes) or **N** (No), and press Enter.
- At the “Select CLINIC SCREEN” prompt, if all the desired entries are removed, press Enter. To remove another, repeat the steps above.

In the following example, CANCER CHEMOTHERAPY is removed.

```
Create/Modify Summary Type                  Feb 09, 2010 12:11:05     Page:  7 of  7
Health Summary: TESTING
+
FLOWSHEET:
<none>

HEALTH FACTORS:
<none>

SUPPLEMENTS:
<none>


Provider Class Screen for OUTPATIENT VISITS (SCREENED) component (IF USED):

CLINIC Screen for OUTPATIENT VISITS (SCREENED) component (IF USED):
Clinics to be EXCLUDED
CANCER CHEMOTHERAPY
     Enter ?? for more actions
MS  Modify Structure   FS  Flow Sheets     GI  General Info
MP  Mod Meas Panel    HF  Health Factors    HS  Sample Health Summary
LP  Lab Panel      PC  Provider Class Scrn Q  Quit
HM  Health Main Remind  CS  Clinic Screen
BP  Best Practice PromptsSP  Supplements
Select Action: +// CS  Clinic Screen

WARNING: OUTPATIENT VISITS SCREENED has not been added to the Health Summary
structure. Entering clinic values into this field will have no affect
unless OUTPATIENT VISITS (SCREENED) is added to the structure.
If the clinic of a visit is a clinic that matches one entered
into this field the visit will NOT display on the summary
in the OUTPATIENT VISITS (SCREENED) section.

To remove a clinic from being screened out of this summary
type the clinic code or name and type an '@',

Select CLINIC SCREEN: CANCER CHEMOTHERAPY// @
  SURE YOU WANT TO DELETE? Y (Yes)
Select CLINIC SCREEN:
```

Figure 4-26: Example of deleting a CLINIC SCREEN

4.8.10 Supplements (SP)

Use the SP option to add a new supplement to the summary type. See Appendix G: for more information about the different types of supplements.

> **Note**: Supplements added to a panel will not display until Supplements is part of the summary structure. For instructions on how to add Supplements as a component in the Health Summary's structure, refer to Section 4.8.1 Modify Structure.

- To add a new supplement, at the "Select Action" prompt, type **SP** and press Enter.
- At the "Select SUPPLEMENT PANEL SEQUENCE" prompt, specify the sequence in which the supplement should display.
- At the "Are you adding'[#]' as a new SUPPLEMENT PANEL SEQUENCE (THE [#] for this HEALTH SUMMARY TYPE)? No//" prompt, type **Y** (Yes) and press Enter to add it to the Health Summary. Type **N** (No) and press Enter to not add it.
- At the "SUPPLEMENT PANEL SEQUENCE SUPPLEMENT PANEL TYPE" prompt, type the name of the supplement to add, and press Enter. If the user does not know the name of the supplement, type two questions (**??**)**,** press Enter to view a list.
- At the "SUPPLEMENT PANEL TYPE" prompt, if the correct supplement displays, press Enter. If not, enter the correct name.
- At the "TIME LIMIT FOR MED DISPLAY" prompt, type the time limit, and press Enter.
- At the "Select SUPPLEMENT PANEL SEQUENCE" prompt, if all desired supplements are added, press Enter. To add another, repeat the steps above.

In the following example, the user adds one new supplement, DIABETIC CARE SUPPLEMENT.

```
Create/Modify Summary Type                  Feb 09, 2010 12:22:38     Page:  7 of  7
Health Summary: TESTING
+
FLOWSHEET:
<none>

HEALTH FACTORS:
<none>

SUPPLEMENTS:
<none>

Provider Class Screen for OUTPATIENT VISITS (SCREENED) component (IF USED):

CLINIC Screen for OUTPATIENT VISITS (SCREENED) component (IF USED):
```

```
     Enter ?? for more actions
MS  Modify Structure   FS  Flow Sheets     GI  General Info
MP  Mod Meas Panel    HF  Health Factors    HS  Sample Health Summary
LP  Lab Panel      PC  Provider Class Scrn Q  Quit
HM  Health Main Remind  CS  Clinic Screen
BP  Best Practice PromptsSP  Supplements
Select Action: +// SP  Supplements

WARNING: SUPPLEMENTS has not been added to the Health Summary Structure.
The SUPPLEMENTS you add to this panel will not display until SUPPLEMENTS is a part
of the summary structure.

Select SUPPLEMENT PANEL SEQUENCE: 10
 Are you adding '10' as a new SUPPLEMENT PANEL SEQUENCE (the 1ST for this HEALTH
SUMMARY TYPE)? No// Y (Yes)

  SUPPLEMENT PANEL SEQUENCE SUPPLEMENT PANEL TYPE: DIABETIC CARE SUMMARY

 SUPPLEMENT PANEL TYPE: DIABETIC CARE SUMMARY//
 TIME LIMIT FOR MED DISPLAY: 2Y
Select SUPPLEMENT PANEL SEQUENCE:
```

Figure 4-27: Example of adding one new supplement

- To remove a supplement class, at the “Select Action” prompt, type **SP** and press Enter.

At the “Select SUPPLEMENT PANEL SEQUENCE” prompt:

- If the supplement to remove is the default option, type the at sign (**@**) and press Enter.
- If the supplement to remove is not the default option, type the order number of the supplement to remove and press Enter.
- At the “SURE YOU WANT TO DELETE THE ENTIRE ‘SEQUENCE’ SUPPLEMENT PANEL SEQUENCE?” prompt, type **Y** (Yes) or **N** (No), and press Enter.
- At the “Select SUPPLEMENT PANEL SEQUENCE” prompt, if all the desired entries are removed, press Enter. To remove another, repeat the steps above.

In the following example, DIABETIC CARE SUMMARY is removed.

```
Create/Modify Summary Type                  Feb 09, 2010 12:23:01     Page:  7 of  7
Health Summary: TESTING
+
FLOWSHEET:
<none>

HEALTH FACTORS:
<none>

SUPPLEMENTS:
Order Supplement
10  DIABETIC CARE SUMMARY 2Y
```

```
Provider Class Screen for OUTPATIENT VISITS (SCREENED) component (IF USED):

CLINIC Screen for OUTPATIENT VISITS (SCREENED) component (IF USED):

     Enter ?? for more actions
MS  Modify Structure   FS  Flow Sheets     GI  General Info
MP  Mod Meas Panel    HF  Health Factors    HS  Sample Health Summary
LP  Lab Panel      PC  Provider Class Scrn Q  Quit
HM  Health Main Remind  CS  Clinic Screen
BP  Best Practice PromptsSP  Supplements
Select Action: +// SP  Supplements

WARNING: SUPPLEMENTS has not been added to the Health Summary Structure.
The SUPPLEMENTS you add to this panel will not display until SUPPLEMENTS is a part
of the summary structure.

Select SUPPLEMENT PANEL SEQUENCE: 10// @


  SURE YOU WANT TO DELETE THE ENTIRE '10' SUPPLEMENT PANEL SEQUENCE? Y (Yes)
Select SUPPLEMENT PANEL SEQUENCE:


BP  Best Practice PromptsSP  Supplements

Create/Modify Summary Type                  Feb 09, 2010 12:23:09     Page:  7 of  7
Health Summary: TESTING
+
FLOWSHEET:
<none>

HEALTH FACTORS:
<none>

SUPPLEMENTS:
<none>

Provider Class Screen for OUTPATIENT VISITS (SCREENED) component (IF USED):

CLINIC Screen for OUTPATIENT VISITS (SCREENED) component (IF USED):

     Enter ?? for more actions
MS  Modify Structure   FS  Flow Sheets     GI  General Info
MP  Mod Meas Panel    HF  Health Factors    HS  Sample Health Summary
LP  Lab Panel      PC  Provider Class Scrn Q  Quit
HM  Health Main Remind  CS  Clinic Screen
BP  Best Practice PromptsSP  Supplements

Select Action: +//
```

Figure 4-28: Example of removing a summary

4.8.11 General Info (GI)

Use the GI option to determine various display elements for the Health Summary output. The following prompts display when using the GI option:

1. At the “Clinic Displayed” prompt, type **Y** (Yes) or **N** (No). This field controls whether or not the clinic will be displayed in any components where clinic applies (e.g., Outpatient/Field Encounters). The text displayed is obtained from the CLINIC STOP file. The Abbreviation field will be used if present; if not, the first 10 characters of the clinic stop name will be used instead.

Note	Using the initial portion of the clinic stop name may result in ambiguity if more than one clinic name begins with the same first 10 characters.

2. At the “ICD Text Displayed” prompt, type one of the following: **L** (long text), **S** (short text), **C** (code only), or **N** (none). This field applies to all components where ICD is involved (e.g., problem list, purpose of visit, etc.). This control is independent of whether or not ICD text displays, either or both can be specified. If neither is specified, provider narrative displays by default.
3. At the “Provider Narrative Displayed” prompt, type **Y** or **N**. This field applies to all components where provider narrative is involved (e.g., problem list, purpose of visit, etc.). This control is independent of whether or not ICD text displays, either or both can be specified. If neither is specified, provider narrative displays by default.
4. At the “Display Provider Initials in Outpatient components” prompt, type **Y** (Yes) or **N** (No).
5. At the “Display PROV Initials W/MEDS” prompt, type **Y** (Yes) or **N** (No).
6. At the “Display Comments W/LAB” prompt, type **Y** (Yes) or **N** (No).

The following shows the information displayed in the General Information screen.

```
GENERAL:
Clinic Displayed on outpatient components: NO
ICD Text Display: NONE
Provider Narrative Displayed: YES
Display Provider Initials in Outpatient components:
Provider Initials displayed on Medication components:
MEASUREMENT PANELS: <none>
LAB TEST PANELS: <none>
HEALTH MAINTENANCE REMINDERS: <none>
BEST PRACTICE PROMPTS: <none>
FLOWSHEET: <none>
HEALTH FACTORS: <none>
SUPPLEMENTS: <none>
Provider Class Screen for OUTPATIENT VISITS (SCREENED) component (IF
USED):

CLINIC Screen for OUTPATIENT VISITS (SCREENED) component (IF USED):

Select Action: +// GI General Info
CLINIC DISPLAYED: Y YES
ICD TEXT DISPLAYED: L LONG TEXT
```

```
PROVIDER NARRATIVE DISPLAYED: Y YES
DISPLAY PROVIDER INITIALS: Y YES
DISPLAY PROV INITIALS W/MEDS: Y YES
DISPLAY COMMENTS W/LAB: Y YES
```

Figure 4-29: Example General Information screen (GI)

4.8.12 Sample Health Summary (HS)

Use the HS option to display a sample Health Summary for a specified patient. The information displays in the OUTPUT BROWSER screen.

```
Create/Modify Summary Type                  Feb 09, 2010 12:35:20     Page:  1 of  7
Health Summary: TESTING

STRUCTURE:
Order Component                 Max occ Time Alternate Title
5   MEDS - ALL                    1Y
10  MEDS - ALL W/#ISS & ALT NAME           1Y
15  MEDS - ALL WITH # ISSUED             1Y

20  MEDS - CHRONIC                   1Y

25  MEDS - CHRONIC & ACUTE W/ ISSUE HISTORY      1Y
30  MEDS - CHRONIC BY NAME              1Y
35  MEDS - CHRONIC EXCLUDING D/C'ED MEDS       1Y
40  MEDS - CURRENT                   1Y
45  MEDS - CURRENT BY NAME              1Y
50  MEDS - MOST RECENT BY GROUP            1Y
55  MEDS - MOST RECENT OF EACH            1Y
60  MEDS - MOST RECENT SHORT FORM           1Y
+     Enter ?? for more actions

MS  Modify Structure   FS  Flow Sheets     GI  General Info
MP  Mod Meas Panel    HF  Health Factors    HS  Sample Health Summary
LP  Lab Panel      PC  Provider Class Scrn Q  Quit
HM  Health Main Remind  CS  Clinic Screen
BP  Best Practice PromptsSP  Supplements

Select Action: +// HS  Sample Health Summary
Select PATIENT NAME: SMITH,JOHN
OUTPUT BROWSER                           Feb 09, 2010 12:35:29     Page:  1 of  1
TESTING Health Summary for SMITH,JOHN


******** CONFIDENTIAL PATIENT INFORMATION -- 2/9/2010 12:35 PM [LAF] ********
********** SMITH,JOHN #1111  (TESTING SUMMARY) pg 1 **********
```

Figure 4-30: Example of Sample Health Summary (HS) option

4.9 Create/Modify Measurement Panel (MM)

The Health Summary package provides an option for constructing custom measurement panels which allows the user to specify the types of measurements that display in a single panel. The custom panel can then be used in a health summary type.

These panels are useful to display only certain types of measurements in a Health Summary; for instance, a user may want to display one set of measurements in a Health Summary for a diabetic clinic visit, and a different set of measurements in a Health Summary for an emergency clinic visit. These custom panels must be created prior to incorporating them in a health summary type.

1. At the “Build Health Summary Option” prompt, type **MM**.
2. At the “Select HEALTH SUMMARY MEAS PANEL NAME” prompt, specify the panel name.
3. A new Health Summary Meas Panel can also be used. This field contains the name of the measurement panel, as referenced in the selecting field of the HEALTH SUMMARY TYPE file. The capability to define named sets of measurements is provided because of the likelihood that measurement groupings will be reused across summary types.
4. At the “Select Order in Panel” prompt, specify the relative order in which the individual measurements making up the panel will display. The values need not be sequential, and need not be entered in order (e.g., items entered in the order “5, 10, 7” will display in the order “5, 7, 10”).
5. Use one of the following (for an existing value): 5 5 (HT), 10 10 (WT), 15 15 (BP), 20 20 (WT), 25 25 (WT), 30 30 (VU), 35 35 (VC).

   Otherwise, specify a new Order In Panel.

6. At the “Panel Component” prompt, specify the measurement to be processed and display in the order indicated. The measurement is chosen from those available in the MEASUREMENT TYPE file (i.e., HT).
7. The following shows a partial list of valid entries: ADM (Asthma Work/School Days Missed), AG (Abdominal Girth), AKBP (Ankle Blood Pressure), ASFD (Asthma Symptom Free Days), ASQF (ASQ–Fine Motor), ASQG (ASQ–Gross Motor), ASQL (ASQ–Language), ASQM (ASQ Questionnaire (Mos)), ASQP (ASQ–Problem Solving), ASQP (ASQ Problem Solving), ASQS (ASQ–Social), AUD (Audiometry).
8. At the “Field Width” prompt, specify how many columns in the display (or printout) the measurement will occupy. If a value containing a decimal point is entered, the decimal value is used to format the measurement. Refer to Section 4.9.1 for more information about this prompt.

For example, a value of 123.45 will display as:

- 123.45 if Field Width is 6.2
- 123.4 if Field Width is 6.1
- 123 if Field Width is 6.0

9. At the “Label” prompt, the contents will be used as the column label instead of the measurement name. Otherwise, the column containing the measurement is labeled with the name of the measurement as it appears in the MEASUREMENT TYPE file.
10. For users with Programmer privileges, the “Transform” prompt displays. Refer to Section 4.9.2 below for more information.
11. At the “Note to Display” prompt, type a line of text to be displayed any time a measurement of the indicated type appears in a panel. For example, if the measurement is Body Mass Index, text in this field might be “Body Mass Index assumes medium frame.”
12. After typing the text to display in the above prompt, the “Select Order in Panel” prompt displays. Type a caret (^) to go to the “Select Health Summary Meas Panel Name” prompt. Here another health summary measure panel name can be added.

```
  IS   Inquire About a Health Summary Type
  PP   Print Health Maintenance Item Protocols
  LS   List Health Summary Types
  LC   List Health Summary Components
  LM   List Measurement Panel Types
  LF   List Health Summary Flowsheets
  LI   List Health Summary Flowsheet Items
  MS   Create/Modify Health Summary Type
  MM   Create/Modify Measurement Panel
  MF   Create/Modify Flowsheet
  HS   Generate Health Summary
  BRHS  Browse Health Summary
  FMMT  Create/Modify Health Summary Type using Fileman
  HSSP  Update Health Summary Site parameters
  PWH  Patient Wellness Handout Menu ...
Select Build Health Summary Option: MM Create/Modify Measurement
Panel

Select HEALTH SUMMARY MEAS PANEL NAME: ??

  Choose from:
  ADULT STD
  ADULT STD METRIC
  PEDIATRIC STD
  PEDIATRIC STD METRIC
  TEST

    You may enter a new HEALTH SUMMARY MEAS PANEL, if you wish
```

```
    This field contains the name of the measurement panel, as
referenced in the selecting field in the HEALTH SUMMARY TYPE file.
The capability to define names sets of measurements is provided
because of the complexity of the definition process and the
likelihood that measurement groupings will be reused across summary
types.

Select HEALTH SUMMARY MEAS PANEL NAME: TEST

-- NOTE: Programmer privileges (FileMan access code of "@") are
required to view
 and modify the TRANSFORM field.

NAME: TEST//
Select ORDER IN PANEL: 10//
 ORDER IN PANEL: 10//
 PANEL COMPONENT: HT//
 FIELD WIDTH: 6.0//
 LABEL: HEIGHT//
 NOTE TO DISPLAY: THIS IS THE HEIGHT//
Select ORDER IN PANEL:

Select HEALTH SUMMARY MEAS PANEL NAME:
```

Figure 4-31: Adding a new HEALTH SUMMARY MEAS PANEL NAME

4.9.1 Specifying the Field Width

A field width for each of the measurement values selected in a custom measurement panel will have to be specified. The measurement values are always displayed right-justified in each field. A field will be filled with asterisks if an attempt is made to display a value that is too large for the field. When prompted to type a field width, specify the width using one of the following formats.

- An Integer. The integer represents the number of column positions for the Measurement Value field, and does not take into account measurement values that contain a decimal point. Regardless of the presence of a decimal point, all values will be right aligned. If the user types a field width of **3**, for example, the field will hold a number like 123 or 1.5, but not 12.3.
- A Pair of Integers Separated by a Decimal Point. In this form, the first integer is the field width and the second integer is the number of decimal places to be displayed. For example, if the user types **6.3**, this means 6 column positions with 3 decimal places. This field will hold a number such as 12.345, but not 123.456.
- An Integer Followed by a Decimal Point and a Zero. This form is a special case of the previous form. The integer specifies the number of column positions, and the zero indicates that no decimal places will be displayed, regardless of the presence of a fraction in the measurement value. If non-integral, the value will be rounded. Any number 0.5 and above is rounded up. For example, a height of 69.5 would be rounded up to 70.

4.9.2 Defining a Transform

The ability to transform stored values makes it possible to display measurements other than those contained in the database. In the measurement panels distributed with the Health Summary package, this capability is used to create height and weight percentiles, percent recommended weight, BMI, metric measurement displays, and separation of measurement data for the left and right eyes. Transforms can be created by programmers for inclusion in custom measurement panels.

> **Note**: *Only* users with programming privileges will see the transform prompt when creating a measurement panel.

A transform is a line of MUMPS code that takes as input a value in the variable X, performs some computation or manipulation, and leaves a value in X to be displayed in the Health Summary.

- Example 1: The display of visual acuity data in the form “20/xx-20/yy” is created via a transform of data representing both eyes, which is stored in the form “xx/yy.” The transform is:
  S X="20/"_$P(X,"/",1)_"-20/"_$P(X,"/",2)
- Example 2: The display of BMI is created via a transform of weight data; the computation is complex and carried out in a routine. The transform is:
  D BMI^APCHS2A1

4.9.3 Constructing a Measurement Panel Example

Below is an example of a measurement panel.

```
Select Health Summary Maintenance Option: MM Create/Modify
Measurement Panel

Select HEALTH SUMMARY MEAS PANEL NAME: DEMO PANEL
NAME: DEMO PANEL // <ENTER>
Select ORDER IN PANEL: 10
 ORDER IN PANEL PANEL COMPONENT: TMP  TEMPERATURE
 PANEL COMPONENT: TMP// <ENTER>
 FIELD WIDTH: 12
 LABEL: <ENTER>
 NOTE TO DISPLAY: TEMPERATURE
```

Figure 4-32: Measurement Panel example

4.10 Create/Modify Flowsheet (MF)

Use the MF option to create or modify a flowsheet. This option also allows the user to build prepackaged tabular displays of specific types of data. The flowsheet created can then be used in a health summary type. Remember that the user must locally create all flowsheets. Follow these steps:

1. At the “Build Health Summary Option” prompt, type **MF**.
2. At the “Select Health Summary Flowsheet Name” prompt, specify a name for the new/existing flowsheet.
3. If an existing flowsheet name was typed, the application displays the name. If this is correct, press Enter to continue. If this is *not* the correct name, specify another existing name.
4. If a new flowsheet name was typed, the application asks if the user is adding a new flowsheet (displays the new name). At this prompt type **Y** (Yes) to continue. Otherwise, type **N** (No) and type another name. If the user accepts the new name, the application displays it at the “Name” prompt.
5. At the “Gender Restrictions” prompt, the user can specify if any gender is restricted by this flowsheet. If so, type **F** (for female) or **M** (for male). The user can leave this field blank by pressing Enter.
6. At the “Lower Age Limit” prompt, type the lower age limit, if any.
7. At the “Upper Age Limit” prompt, type the lower age limit, if any.
8. At the “Select Item Order” prompt, a new structure can be used. This field contains an integer that specifies the relative order in which the flowsheet items will be displayed. Values need not be sequential or entered in order. For example, items entered in the order “5, 10, 7” will display in the order “5, 7, 10.”
9. At the “Item Type” prompt, specify the type of item to be displayed in the specified relative order. The item is chosen from those available in the HEALTH SUMMARY FLOWSHEET ITEMS file. The user can choose one of the following: Examination, Health factor, Laboratory result, Measurement, Medication, Patient education, or Purpose of visit.
10. At the “Item Label” prompt, specify the name of the item specified in the “Item Type” field. This will be used as the label for the column in which the item appears.
11. At the “Item Width” prompt, specify the width of the column in which the item displays. The sum of all columns plus the number of columns should be less than 70 to display the date at the beginning of each row, and the characters separating columns.
12. At the “Select Members” prompt, specify new members, if desired.
13. This field limits the instances of data of the type specified in the “Item Type” field displayed on the flowsheet. It points to an entry in the file that defines the instances of the class of data represented by the item displayed. For example, if Medication is the type of item displayed the field points to any entry in the DRUG file. Specifically, this field points to an entry in the file specified in the Item Selection File field of the HEALTH SUMMARY FLOWSHEET ITEMS file that corresponds to the type of item displayed.

14. Type one of the following: **MEA.EntryName** to select a Measurement type, **MED.EntryName** to select a Medication, **LAB.EntryName** to select a Lab test, **POV.EntryName** to select a Purpose of visit, **EXM.EntryName** to select a Examinations, **PED.EntryName** to select a Patient education, or **HF.EntryName** to select a Health Factors.
15. If the user types a name, the system will search each of the above files for the name entered. If a match is found, the system will ask if it is the correct entry.
16. If the user knows the file the entry should be in, processing can be speeded up by using the following syntax to select an entry: <Prefix>.<entry name> or <Message>.<entry name> or <File Name>.<entry name>
17. The user does *not* need to enter the entire file name or message to direct the look up. Using the first few characters will suffice.
18. The "Select Item Order" prompt displays again. Type ^ (caret) to return to the "Select Build Health Summary Option" prompt.

```
IS   Inquire About a Health Summary Type
  PP   Print Health Maintenance Item Protocols
  LS   List Health Summary Types
  LC   List Health Summary Components
  LM   List Measurement Panel Types
  LF   List Health Summary Flowsheets
  LI   List Health Summary Flowsheet Items
  MS   Create/Modify Health Summary Type
  MM   Create/Modify Measurement Panel
  MF   Create/Modify Flowsheet
  HS   Generate Health Summary
  BRHS  Browse Health Summary
  FMMT  Create/Modify Health Summary Type using Fileman
  HSSP  Update Health Summary Site parameters
  PWH  Patient Wellness Handout Menu ...
Select Build Health Summary Option: MF Create/Modify Flowsheet

Select HEALTH SUMMARY FLOWSHEET NAME: ???
  DIABETIC FLOWSHEET

    You may enter a new HEALTH SUMMARY FLOWSHEET, if you wish
    This field contains the name of the flowsheet as it will be
specified
    in the FLOWSHEET PANEL multiple in the HEALTH SUMMARY TYPE file.
  Select HEALTH SUMMARY FLOWSHEET NAME: TEST
 Are you adding 'TEST' as a new HEALTH SUMMARY FLOWSHEET (the 2ND)?
No// Y
 (Yes)
NAME: TEST//
GENDER RESTRICTIONS: F FEMALES ONLY
LOWER AGE LIMIT: 18
UPPER AGE LIMIT: 85
Select ITEM ORDER: ??
    You may enter a new STRUCTURE, if you wish
```

```
    This field contains an integer which specifies the relative
order in which the flowsheet items are to be displayed. Values do
not have to be sequential, and need not be entered in order. For
example, items entered in the order 5 10 7 will still display in the
order 5 7 10.

Select ITEM ORDER: 10
  ITEM ORDER ITEM TYPE: ??
    This field specifies a type of item to be displayed in the
specified relative order. The item is chosen from those available in
the HEALTH SUMMARY FLOWSHEET ITEMS file.


  Choose from:
  EXAMINATION
  HEALTH FACTOR
  LAB RESULT
  MEASUREMENT
  MEDICATION
  PATIENT EDUCATION
  PURPOSE OF VISIT

  ITEM ORDER ITEM TYPE: EXAMINATION
 ITEM TYPE: EXAMINATION//
 ITEM LABEL:
 ITEM WIDTH: 80??
   Enter an integer between 1 and 25 specifying the width of the
column used to display the item
 ITEM WIDTH: 25
 Select MEMBERS: ??
    You may enter a new MEMBERS, if you wish
    This field is used to limit the instances of data (of the type
specified by the ITEM TYPE field) displayed on the flowsheet. It
points to an entry in the file which defines the instances of the
class of data represented by the item being displayed. For example,
if MEDICATION is the type of item being displayed, this field points
to an entry in the DRUG file.

    Specifically, this field points to an entry in the file
specified in the ITEM SELECTION FILE field of the entry in the
HEALTH SUMMARY FLOWSHEET ITEMS file which corresponds to the type of
item being displayed.
    Enter one of the following:
     MEA.EntryName to select a Measurement type
     MED.EntryName to select a Medication
     LAB.EntryName to select a Lab test
     POV.EntryName to select a Purpose of visit
     EXM.EntryName to select a Examinations
     PED.EntryName to select a Patient education
     HF.EntryName to select a Health Factors

    To see the entries in any particular file type <Prefix.?>
If you simply enter a name then the system will search each of
the above files for the name you have entered. If a match is
found the system will ask you if it is the entry that you desire.
```

```
    However, if you know the file the entry should be in, then you
can speed processing by using the following syntax to select an
entry:
       <Prefix>.<entry name>
            or
       <Message>.<entry name>
            or
       <File Name>.<entry name>

    Also, you do NOT need to enter the entire file name or message
    to direct the look up. Using the first few characters will
suffice.

 Select MEMBERS: EXM

   Searching for a Measurement type, (pointed-to by MEMBERS)

   Searching for a Medication, (pointed-to by MEMBERS)

   Searching for a Lab test, (pointed-to by MEMBERS)

   Searching for a Purpose of visit, (pointed-to by MEMBERS)
Narrative contained no useable words.
Search was unsuccessful.

   Searching for a Examinations, (pointed-to by MEMBERS)

   Searching for a Patient education, (pointed-to by MEMBERS)

   Searching for a Health Factors, (pointed-to by MEMBERS)

Select MEMBERS:
Select ITEM ORDER:
Select EVOKING CODES: ??
    You may enter a new EVOKING CODES, if you wish
    This field can optionally contain an ICD diagnosis code, or
range of codes. If present, the data in this field will be compared
with the patient's problem list: if the patient has any problem
which matches the evoking code(s), the flowsheet will be generated;
otherwise it will be skipped. If no evoking codes are specified, the
flowsheet will be generated under the assumption that no restriction
is desired.

Select EVOKING CODES:
Select CLINIC DISPLAY RESTRICTIONS:
Select HEALTH SUMMARY FLOWSHEET NAME:
```

Figure 4-33: Example of the Create/Modify Flowsheet (MF)

4.11 Generate Health Summary (HS)

Refer to Section 3.1 for information about the Generate Health Summary (HS) prompts.

4.12 Browse Health Summary (BRHS)

Refer to Section 3.2 for information about the Browse Health Summary (BRHS) prompts.

4.13 Create/Modify Health Summary Type Using FileMan (FMMT)

Use the FMMT option to edit a health summary type line-by-line *without* accessing the MS–Create/Modify Health Summary Type option.

- At the “Select Build Health Summary Option” prompt, type FMMT and press Enter.
- At the “Select HEALTH SUMMARY TYPE NAME” prompt, type the name of the health summary to modify, and press Enter.
- At the “Name” prompt, if the correct health summary name displays, press Enter. If it does not, retype the name of the summary and press Enter.
- At the “Lock” prompt, type the lock code, if applicable. If not, press Enter.
- At the “Select SUMMARY ORDER” prompt, type the sequence number of the component to create or modify. If the user does not wish to create/modify the structure of the health summary, press Enter at this prompt. In the example below, the system defaults to the component in sequence number of 10. The user chooses 20 instead to create a new component that follows the component in slot 10.
- At the “STRUCTURE COMPONENT NAME” prompt, if the user is creating/modifying the structure, enter the name of the component to create/modify.
- At the “COMPONENT NAME” prompt, if the correct component displays as the default (what was entered in the previous step), press Enter. If not, retype the component name and press Enter.
- At the “ALTERNATE TITLE” prompt, type the name an alternative name for the component, if desired. In the example below, the user wants “BPP” to display for the component name in the health summary instead of “Best Practice Prompts.”

Depending on the component being created/modified, the prompts may differ, depending on the required information for the component to display. In the example below, the prompts for the Best Practice Prompts component and the Measurements component vary.

- At the “Select SUMMARY ORDER” prompt, if all structural changes are completed, press Enter. If not, repeat the steps above.

At the subsequent display-related prompts, type **Y** (Yes) for the specified data type to display in the health summary or **N** (No).

- CLINIC DISPLAYED
- DISPLAY PROVIDER INITIALS
- DISPLAY PROV INITIALS W/ MEDS (Provider Initials with Medications)
- ICD TEXT DISPLAYED
- PROVIDER NARRATIVE DISPLAYED
- DISPLAY COMMENTS W/ LAB (Comments with Laboratory results)

At the subsequent sequence-related prompts, type the sequence number of the item to create/modify and press Enter.

- Select MEASUREMENT PANEL SEQUENCE
- Select LAB TEST SEQUENCE
- Select SURVEILLANCE ITEM SEQUENCE
- Select FLOWSHEET SEQUENCE
- Select HEALTH FACTOR SEQUENCE
- Select PROVIDER CLASS SCREEN
- Select CLINIC SCREEN
- Select SUPPLEMENT PANEL SEQUENCE
- Select BEST PRACTICE PROMPT ORDER

The system will prompt the user for the item type, such as in the SURVEILLANCE ITEM example below. The prompts are exactly the same as those detailed in Section 4.8, Create/Modify Health Summary Type (MS).

- If the user does not want to create/modify the item, press Enter at the prompt.
- At the “Select SUMMARY ORDER” prompt, type the sequence number of the component to create or modify. If the user does not wish to create/modify the structure of the health summary, press Enter at this prompt. In the example below, the system defaults to the component in sequence number of 10. The user chooses 20 instead to create a new component that follows the component in slot 10.
- At the “STRUCTURE COMPONENT NAME” prompt, if the user is creating/modifying the structure, type the name of the component to create/modify.
- At the “SELECT MEASUREMENT PANEL SEQUENCE” prompt, type the sequence number of the measurement panel to create/modify, and press Enter. If the user does not want to create/modify a measurement panel, press Enter.

```
IS   Inquire About a Health Summary Type
PP   Print Health Maintenance Item Protocols
LS   List Health Summary Types
```

```
  LC   List Health Summary Components
  LM   List Measurement Panel Types
  LF   List Health Summary Flowsheets
  LI   List Health Summary Flowsheet Items
  MS   Create/Modify Health Summary Type
  MM   Create/Modify Measurement Panel
  MF   Create/Modify Flowsheet
  HS   Generate Health Summary
  BRHS  Browse Health Summary
  FMMT  Create/Modify Health Summary Type using Fileman
  HSSP  Update Health Summary Site parameters
  PWH  Patient Wellness Handout Menu ...

Select Build Health Summary Option: FMMT Create/Modify Health
Summary Type using Fileman

Select HEALTH SUMMARY TYPE NAME: TEST
NAME: TEST//
LOCK:

Select SUMMARY ORDER: 10// 20
  STRUCTURE COMPONENT NAME: BEST PRACTICE PROMPTS
 COMPONENT NAME: BEST PRACTICE PROMPTS//
 ALTERNATE TITLE: BPP
Select SUMMARY ORDER: 30
  STRUCTURE COMPONENT NAME: MEASUREMENTS
 COMPONENT NAME: MEASUREMENTS//
 MAXIMUM OCCURRENCES: 5
 TIME LIMIT: 2Y
 ALTERNATE TITLE:
Select SUMMARY ORDER:
CLINIC DISPLAYED: Y YES
DISPLAY PROVIDER INITIALS: Y YES
DISPLAY PROV INITIALS W/MEDS: Y YES
ICD TEXT DISPLAYED: N NONE
PROVIDER NARRATIVE DISPLAYED: Y YES
DISPLAY COMMENTS W/LAB: Y YES
Select MEASUREMENT PANEL SEQUENCE:
Select LAB TEST SEQUENCE:
Select SURVEILLANCE ITEM SEQUENCE: 30//
 SURVEILLANCE ITEM SEQUENCE: 30//
 SURVEILLANCE ITEM TYPE: PAP SMEAR//
Select SURVEILLANCE ITEM SEQUENCE: 40
  SURVEILLANCE ITEM SEQUENCE SURVEILLANCE ITEM TYPE: MAMMOGRAM
 SURVEILLANCE ITEM TYPE: MAMMOGRAM//
Select SURVEILLANCE ITEM SEQUENCE:
Select FLOWSHEET SEQUENCE:
Select HEALTH FACTOR SEQUENCE: 10
  HEALTH FACTOR SEQUENCE HEALTH FACTOR TYPE: ASTHMA TRIGGERS
ASTHMA TRIGGERS
 HEALTH FACTOR TYPE: ASTHMA TRIGGERS//
 HEALTH FACTOR TITLE:
 DISPLAY MOST RECENT INSTANCE: Y MOST RECENT ONLY DISPLAYED
Select HEALTH FACTOR SEQUENCE:
Select PROVIDER CLASS SCREEN:
```

```
Select CLINIC SCREEN:
Select SUPPLEMENT PANEL SEQUENCE:
Select BEST PRACTICE PROMPT ORDER: 10
 BEST PRACTICE PROMPT: ANTICOAGULATION: ANTICOAGULATION THERAPY END
DATE
Select BEST PRACTICE PROMPT ORDER:
Select HEALTH SUMMARY TYPE NAME:
```

Figure 4-34: Example of Create/Modify Health Summary Type using Fileman (FMMT)

4.14 Update Health Summary Site Parameters (HSSP)

Use the HSSP option to edit health summary site parameters. Follow these steps:

1. At the “Select “Build Health Summary Option” prompt, type **HSSP**.
2. At the “Select Health Summary Site Parameters Site Name” prompt, specify the name of the site. For example,

```
  IS   Inquire About a Health Summary Type
  PP   Print Health Maintenance Item Protocols
  LS   List Health Summary Types
  LC   List Health Summary Components
  LM   List Measurement Panel Types
  LF   List Health Summary Flowsheets
  LI   List Health Summary Flowsheet Items
  MS   Create/Modify Health Summary Type
  MM   Create/Modify Measurement Panel
  MF   Create/Modify Flowsheet
  HS   Generate Health Summary
  BRHS  Browse Health Summary
  FMMT  Create/Modify Health Summary Type using Fileman
  HSSP  Update Health Summary Site parameters
  PWH  Patient Wellness Handout Menu ...

Select Build Health Summary Option: HSSP Update Health Summary Site
parameters

Select HEALTH SUMMARY SITE PARAMETERS SITE NAME: DEMO DEMO HOSPITAL
     ...OK? Yes//  (Yes)

        Updating Health Summary Site Parameters
           DEMO HOSPITAL

Switch to the Diabetes Summary when Diabetes is on the problem list
and summaries are printed through the Scheduling module? NO
Default Diabetes Summary Type:

SUPPLEMENT # Diagnoses/Date Range Limits (press enter):

FLOWSHEET # Diagnoses/Date Range Limits (press enter):


# of lines to display for REMARKS in demographic component: 20
```

```
For REMARKS display the FIRST or LAST n # of lines: FIRST
_____________________________________________________________________



COMMAND:          Press <PF1>H for help Insert
```

Figure 4-35: Selecting Health Summary site parameters (HSSP)

The following provides information about prompts in Figure 4-29.

- "Switch to the Diabetes Summary when Diabetes is on the problem list and summaries are printed through the Scheduling module?" prompt is used to control whether or not the summary type automatically switches to the Diabetes Health summary when diabetes is on the patient's problem list and the summary is printed from the scheduling module. For example, when Adult Regular is the default summary for a clinic and diabetes is on the patient's problem list, the Diabetes summary will display instead of the Adult Regular summary.

  To leave the auto-switch on, type **Y** (Yes) in "Default Diabetes Summary Type" prompt, type **N** (No) to disable the auto-switch. If the user types **Y** (Yes), the name of the Diabetes summary type must be entered in the Default Diabetes Summary Type field.

- "Default Diabetes Summary Type" prompt: Type a default name for the Default Diabetes Summary Type or press Enter to bypass the prompt.
- "SUPPLEMENT # Diagnoses/Date Range Limits" prompt: Press Tab to bypass this prompt. If Enter is pressed at this prompt, the following screen displays:

```
A supplement that has diagnoses codes associated with it will only print
when the patient has one of those diagnoses on their active problem list OR
has one of those diagnoses recorded in the past year. You can override the
# of diagnoses and # of years for any supplement by adding it below and
indicating the # of diagnoses years that should be used.

SUPPLEMENT # diagnoses in # years
```

Figure 4-36: Sample dialog box for "Supplement # Diagnoses/Date Range Limits" prompt

- At the last line of this screen, type two question marks (**??**) to view Help.

```
You may enter a new SUPPLEMENT DIAGNOSIS LIMITS, if you wish.
Choose from:
DIABETIC CARE SUMMARY
PRE-DIABETES SUMMARY
Enter RETURN to continue or '^' to exit.
```

Figure 4-37: Help information for supplement diagnosis limits

- Press Enter to return to the screen where a new supplement diagnosis limit can be typed. Type a caret (^) (caret) to exit. At the "Command" prompt, type **Close** to exit. Otherwise, type **Refresh** to refresh the display.
- "FLOWSHEET # Diagnosis/Date Range Limits" prompt: Press Tab to bypass this prompt. If Enter is pressed, the following screen displays:

```
A flowsheet that has diagnoses codes associated with it will only
print when the patient has one of those diagnoses on their active
problem list OR has one of those diagnoses recorded as a purpose of
visit in the past year. You can override the # of diagnoses and the
# of years for any supplement by adding it below and indicating the
# of diagnoses in how many years that should be used.

 FLOWSHEET # diagnoses in # of years
```

Figure 4-38: Example dialog box for "Flowsheet # Diagnosis/Date Range Limits" prompt

- At the last line on this screen, type two question marks (**??**) to display the Help screen:

```
You may enter a new FLOWSHEET DIAGNOSES LIMITS, if you wish
Choose from:
ANTICOAGULATION SERVICE
CARDIOVASCULAR DISEASE
Enter RETURN to continue or '^' to exit.
```

Figure 4-39: Help information for flowsheet diagnoses limits

- Press Enter to return to the prompt where a new flowsheet diagnoses limit can be typed.
- Type a caret (^) to exit the data entry screen. At the "Command" prompt, type **Close** to exit. Otherwise, type **Refresh** to refresh the data on the screen.
- The "# of lines to display for REMARKS in demographic component" prompt is used to specify the number of lines that are available in the REMARKS section of the health summary.

At the end of the session, type one of the following:

- **Exit**: to exit the Updating Health Summary Site Parameters screen. The user will be asked whether or not he/she wants to save.
- **Save**: to save changes. After typing **Y** (Yes) or **N** (No), the "Select Health Summary Site Parameters Site Name" prompt will display. Type a caret (^) to return to the "Select Build Health Summary Option" prompt.
- **Refresh**: to refresh the data on the screen.

4.15 Patient Wellness Handouts (PWH)

Use the PWH option to access the options on the Patient Wellness Handouts menu. Refer to Section 6.0, Patient Wellness Handouts Menu, for detailed information.

5.0 Health Summary Maintenance (HSM)

This section provides instructions for options that pertain to viewing and deleting elements of the Health Summaries. The options for creating and modifying portions of the Health Summaries are discussed in detail in Section 4.0.

To access the options in the Maintenance menu, a manager's key is required.

To access health summary maintenance options from the main Health Summary menu, type **HSM**. The Health Summary Maintenance menu displays.

```
                              ************************************
                              **       I HS Health Summary      **
                              ** Health Summary Maintenance Menu **
                              ************************************
                                    IHS PCC Suite Version 2.0

                                        DEMO HOSPITAL

 IS   Inquire About a Health Summary Type
 HM   Health Maintenance Reminders ...
 PP   Print Health Maintenance Item Protocols
 LS   List Health Summary Types
 LC   List Health Summary Components
 LM   List Measurement Panel Types
 LF   List Health Summary Flowsheets
 LI   List Health Summary Flowsheet Items
 MS   Create/Modify Health Summary Type
 MM   Create/Modify Measurement Panel
 MF   Create/Modify Flowsheet
 MI   Create/Modify Flowsheet Item
 DS   Delete Health Summary Type
 DM   Delete Measurement Panel Definition
 DF   Delete Health Summary Flowsheet
 DI   Delete Health Summary Flowsheet Item
 HS   Generate Health Summary
 BP   Best Practice Prompt Menu ...
 FMMT Create/Modify Health Summary Type using Fileman
 HSSP Update Health Summary Site parameters
 IPT  Update the Major Procedures CPT Taxonomy
 MPT  Update the Minor Procedures CPT Taxonomy
```

Figure 5-1: Options in the Health Summary Maintenance menu

5.1 Inquire About a Health Summary Type (IS)

Use the IS option to view the structure of a specific health summary type. The components that display in the Health Summary are as follows: the order of components, data restrictions, specifications regarding the display of the clinic name, and ICD text. Refer to Section 4.1 for more information.

5.2 Health Maintenance Reminders (HM)

See Section 7.0 Health Maintenance Reminders for complete information about this option and its menu.

5.3 Print Health Maintenance Item Protocols (PP)

Health maintenance reminders are printed in many types of health summaries. The due dates for each item are calculated according to a predefined schedule. The PP option allows the schedule to be reviewed. Refer to Appendix A: for a list of reminders and schedules. Refer to Section 4.2 for more information about the PP option prompts.

5.4 List Health Summary Types (LS)

Use the LS option to view the names of all health summary types that exist at your facility. This list includes the standard health summary types distributed with this package as well as any customized health summaries that were created locally.

The following is a portion of the Health Summary list.

```
  IS   Inquire About a Health Summary Type
  HM   Health Maintenance Reminders ...
  PP   Print Health Maintenance Item Protocols
  LS   List Health Summary Types
  LC   List Health Summary Components
  LM   List Measurement Panel Types
  LF   List Health Summary Flowsheets
  LI   List Health Summary Flowsheet Items
  MS   Create/Modify Health Summary Type
  MM   Create/Modify Measurement Panel
  MF   Create/Modify Flowsheet
  MI   Create/Modify Flowsheet Item
  DS   Delete Health Summary Type
  DM   Delete Measurement Panel Definition
  DF   Delete Health Summary Flowsheet
  DI   Delete Health Summary Flowsheet Item
  HS   Generate Health Summary
  BP   Best Practice Prompt Menu ...
  FMMT  Create/Modify Health Summary Type using Fileman
  HSSP  Update Health Summary Site parameters
  IPT  Update the Minor Procedures CPT Taxonomy
  MPT  Update the Major Procedures CPT Taxonomy
  PWH  Patient Wellness Handout Menu

Select Health Summary Maintenance Option: LS List Health Summary
Types

Existing HEALTH SUMMARY TYPES:
   ADULT REGULAR
   ALL REMINDERS
```

```
   BEHAVIORAL HEALTH
   CHR
   DENTAL
Enter RETURN to continue or '^' to exit:
```

Figure 5-2: Example of listing health summary types (LS)

5.5 List Measurement Panel Types (LM)

Use this option to view a list of the available measurement panels. Both the standard panels distributed with the Health Summary package and any panels that were created at the user's facility will display.

The following is an example list of measurement panels.

```
  IS   Inquire About a Health Summary Type
  HM   Health Maintenance Reminders ...
  PP   Print Health Maintenance Item Protocols
  LS   List Health Summary Types
  LC   List Health Summary Components
  LM   List Measurement Panel Types
  LF   List Health Summary Flowsheets
  LI   List Health Summary Flowsheet Items
  MS   Create/Modify Health Summary Type
  MM   Create/Modify Measurement Panel
  MF   Create/Modify Flowsheet
  MI   Create/Modify Flowsheet Item
  DS   Delete Health Summary Type
  DM   Delete Measurement Panel Definition
  DF   Delete Health Summary Flowsheet
  DI   Delete Health Summary Flowsheet Item
  HS   Generate Health Summary
  BP   Best Practice Prompt Menu ...
  FMMT  Create/Modify Health Summary Type using Fileman
  HSSP  Update Health Summary Site parameters
  IPT  Update the Minor Procedures CPT Taxonomy
  MPT  Update the Major Procedures CPT Taxonomy
  PWH  Patient Wellness Handout Menu

Select Health Summary Maintenance Option: LM List Measurement Panel
Types

Existing HEALTH SUMMARY MEAS PANELS:

   ADULT STD
   ADULT STD METRIC
   PEDIATRIC STD
   PEDIATRIC STD METRIC
Enter RETURN to continue or '^' to exit:
```

Figure 5-3: Example of listing measurement panel types (LM)

5.6 List Health Summary Components (LC)

Use this option to view a list of available health summary components. See Appendix G: for more information about the components. Refer to Section 4.4 for more information about the LC option prompts.

5.7 List Health Summary Flowsheets (LF)

Use the LF option to display the names of the flowsheets that exist at the user's facility. Remember that all flowsheets must be created locally. No flowsheets were distributed with this package. To use the option, select it from the Maintenance menu. The list of flowsheet names will display on the screen.

The following is an example list of flowsheets.

```
  IS   Inquire About a Health Summary Type
  HM   Health Maintenance Reminders ...
  PP   Print Health Maintenance Item Protocols
  LS   List Health Summary Types
  LC   List Health Summary Components
  LM   List Measurement Panel Types
  LF   List Health Summary Flowsheets
  LI   List Health Summary Flowsheet Items
  MS   Create/Modify Health Summary Type
  MM   Create/Modify Measurement Panel
  MF   Create/Modify Flowsheet
  MI   Create/Modify Flowsheet Item
  DS   Delete Health Summary Type
  DM   Delete Measurement Panel Definition
  DF   Delete Health Summary Flowsheet
  DI   Delete Health Summary Flowsheet Item
  HS   Generate Health Summary
  BP   Best Practice Prompt Menu ...
  FMMT  Create/Modify Health Summary Type using Fileman
  HSSP  Update Health Summary Site parameters
  IPT  Update the Minor Procedures CPT Taxonomy
  MPT  Update the Major Procedures CPT Taxonomy
  PWH  Patient Wellness Handout Menu

Select Health Summary Maintenance Option: LF List Health Summary
Flowsheets

Existing HEALTH SUMMARY FLOWSHEETS:

   DIABETIC FLOWSHEET
   TEST
```

Figure 5-4: Example of listing flowsheets types (LF)

5.8 List Health Summary Flowsheet Items (LI)

Use the LI option to display a class of items used for creating flowsheets. Follow these steps:

1. At the “Health Summary Maintenance Option” prompt, type LI to display a list of the existing health summary flowsheet items.

```
  IS   Inquire About a Health Summary Type
  HM   Health Maintenance Reminders ...
  PP   Print Health Maintenance Item Protocols
  LS   List Health Summary Types
  LC   List Health Summary Components
  LM   List Measurement Panel Types
  LF   List Health Summary Flowsheets
  LI   List Health Summary Flowsheet Items
  MS   Create/Modify Health Summary Type
  MM   Create/Modify Measurement Panel
  MF   Create/Modify Flowsheet
  MI   Create/Modify Flowsheet Item
  DS   Delete Health Summary Type
  DM   Delete Measurement Panel Definition
  DF   Delete Health Summary Flowsheet
  DI   Delete Health Summary Flowsheet Item
  HS   Generate Health Summary
  BP   Best Practice Prompt Menu ...
  FMMT  Create/Modify Health Summary Type using Fileman
  HSSP  Update Health Summary Site parameters
  IPT  Update the Minor Procedures CPT Taxonomy
  MPT  Update the Major Procedures CPT Taxonomy
  PWH  Patient Wellness Handout Menu

Select Health Summary Maintenance Option: LI List Health Summary
Flowsheet Items

Existing HEALTH SUMMARY FLOWSHEET ITEMS:

   EXAMINATION
   HEALTH FACTOR
   LAB RESULT
   MEASUREMENT
   MEDICATION
   PATIENT EDUCATION
   PURPOSE OF VISIT
Enter RETURN to continue or '^' to exit:
```

Figure 5-5: Example of listing flowsheet items (LI)

5.9 Create/Modify Health Summary Type (MS)

Refer to Section 4.8, Create/Modify Health Summary Type (MS), for detailed instructions.

5.10 Create/Modify Measurement Panel (MM)

Use the MM option to create/modify available measurement panels without navigating to the MS – Create/Modify Health Summary Type menu and the MM Create/Modify Measurement Panel sub-menu.

Refer to Section 4.9, Create/Modify Measurement Panel (MM), for detailed instructions about this option. The prompts are the same.

5.11 Create/Modify Flowsheet (MF)

Refer to Section 4.10, Create/Modify Flowsheet (MF), for detailed instructions about this option. The prompts are the same.

5.12 Create/Modify Flowsheet Item (MI)

Use the MI option to create or modify a flowsheet item. Only programmers should be using this option.

> **Note**: Programmer privileges (FileMan access code of "@") are required to access the remainder of this file.

Follow these steps:

1. At the “Health Summary Maintenance Option” prompt, type **MI**.
2. At the “Health Summary Flowsheet Items Name” prompt, specify the name of the flowsheet item. This name will display in the definition for the flowsheet. Each item represents a class of data, e.g., Medication represents medication data.
4. At the “Item Selection File” prompt, specify the file that contains instances of the data class represented by the flowsheet item. For example, if the item is Medication, the item selection file is the Drug file.
5. At the “Data File” prompt, specify the file in which PCC stores uses of the data class represented by the flowsheet item. For example, if the item is Medication, the data file is V Medication.
6. At the “Value Extraction Logic” prompt, the application displays the MUMPS code, which returns a value to be displayed as part of a flowsheet. For example, if the item is Medication, the code returns the concatenation of the drug name, the number dispensed, the instructions (signature), and date discontinued (if any).

> **Note**: Only users with programmer privileges can use this field.

The variable DA will contain the internal entry number of the relevant V-file entry.

1. At the “Replace” prompt, specify the correct MUMPS code.

2. At the “Type Extraction Logic” prompt, the application displays the MUMPS code and returns the value (usually a pointer) compared to the list of instances of the data class to be displayed (if entered in the flowsheet definition).
3. At the “Replace” prompt, specify the correct MUMPS code.

5.13 Delete Health Summary Type (DS)

Use the DS option to delete a specified health summary type. For instance, it may be necessary to delete customized Health Summaries if they are no longer used at a facility. Follow these steps:

1. At the “Health Summary Maintenance Option” prompt, type **DS**.
2. At the “Select HEALTH SUMMARY TYPE NAME” prompt, specify the name of the health summary type to be deleted, then press Enter.
3. At the “SURE YOU WANT TO DELETE THIS SUMMARY TYPE?” prompt, type **Y** (Yes) or **N** (No), then press Enter.

```
  IS   Inquire About a Health Summary Type
  HM   Health Maintenance Reminders ...
  PP   Print Health Maintenance Item Protocols
  LS   List Health Summary Types
  LC   List Health Summary Components
  LM   List Measurement Panel Types
  LF   List Health Summary Flowsheets
  LI   List Health Summary Flowsheet Items
  MS   Create/Modify Health Summary Type
  MM   Create/Modify Measurement Panel
  MF   Create/Modify Flowsheet
  MI   Create/Modify Flowsheet Item
  DS   Delete Health Summary Type
  DM   Delete Measurement Panel Definition
  DF   Delete Health Summary Flowsheet
  DI   Delete Health Summary Flowsheet Item
  HS   Generate Health Summary
  BP   Best Practice Prompt Menu ...
  FMMT  Create/Modify Health Summary Type using Fileman
  HSSP  Update Health Summary Site parameters
  IPT  Update the Minor Procedures CPT Taxonomy
  MPT  Update the Major Procedures CPT Taxonomy

        Press 'RETURN' to continue, '^' to stop: ^

Select Health Summary Maintenance Option: DS Delete Health Summary
Type
```

```
Select HEALTH SUMMARY TYPE NAME: TESTING
SURE YOU WANT TO DELETE THIS SUMMARY TYPE? No// Y (Yes)

Select HEALTH SUMMARY TYPE NAME:
```

Figure 5-6: Example of deleting a health summary type (DS)

5.14 Delete Measurement Panel Definition (DM)

Use the DM option to delete a specified measurement panel. Prior to deleting a measurement panel, check to make sure it is not used by any of the health summary types generated at your facility. Follow these steps:

1. At the “Health Summary Maintenance Option” prompt, type **DM**.
2. At the “Select HEALTH SUMMARY MEAS PANEL NAME” prompt, specify the name of the measurement panel definition to be deleted, then press Enter.
3. At the “SURE YOU WANT TO DELETE THIS MEASUREMENT PANEL?” prompt, type either **Y** (Yes) or **N** (No), then press Enter.

```
  IS   Inquire About a Health Summary Type
  HM   Health Maintenance Reminders ...
  PP   Print Health Maintenance Item Protocols
  LS   List Health Summary Types
  LC   List Health Summary Components
  LM   List Measurement Panel Types
  LF   List Health Summary Flowsheets
  LI   List Health Summary Flowsheet Items
  MS   Create/Modify Health Summary Type
  MM   Create/Modify Measurement Panel
  MF   Create/Modify Flowsheet
  MI   Create/Modify Flowsheet Item
  DS   Delete Health Summary Type
  DM   Delete Measurement Panel Definition
  DF   Delete Health Summary Flowsheet
  DI   Delete Health Summary Flowsheet Item
  HS   Generate Health Summary
  BP   Best Practice Prompt Menu ...
  FMMT  Create/Modify Health Summary Type using Fileman
  HSSP  Update Health Summary Site parameters
  IPT  Update the Minor Procedures CPT Taxonomy
  MPT  Update the Major Procedures CPT Taxonomy

        Press 'RETURN' to continue, '^' to stop: ^

Select Health Summary Maintenance Option: DM Delete Measurement
Panel Definition

Select HEALTH SUMMARY MEAS PANEL NAME: TESTING
SURE YOU WANT TO DELETE THIS MEASUREMENT PANEL? No// Y (Yes)

Select HEALTH SUMMARY MEAS PANEL NAME:
```

Figure 5-7: Example of deleting a measurement panel definition (DM)

5.15 Delete Health Summary Flowsheet (DF)

Use the DF option to delete a specified flowsheet. Once the flowsheet is deleted, it will not appear in any Health Summaries that reference it. Review the Health Summaries in use at your facility to ensure that the deletion will not have any adverse effects. Follow these steps:

1. At the “Health Summary Maintenance Option” prompt, type **DF**.
2. At the “Select HEALTH SUMMARY FLOWSHEET NAME” prompt, specify the name of the Health Summary flowsheet to be deleted, then press Enter.
3. At the”SURE YOU WANT TO DLETE THIS FLOWSHEET?” prompt, type either **Y** (Yes) or **N** (No), then press Enter.

```
  IS   Inquire About a Health Summary Type
  HM   Health Maintenance Reminders ...
  PP   Print Health Maintenance Item Protocols
  LS   List Health Summary Types
  LC   List Health Summary Components
  LM   List Measurement Panel Types
  LF   List Health Summary Flowsheets
  LI   List Health Summary Flowsheet Items
  MS   Create/Modify Health Summary Type
  MM   Create/Modify Measurement Panel
  MF   Create/Modify Flowsheet
  MI   Create/Modify Flowsheet Item
  DS   Delete Health Summary Type
  DM   Delete Measurement Panel Definition
  DF   Delete Health Summary Flowsheet
  DI   Delete Health Summary Flowsheet Item
  HS   Generate Health Summary
  BP   Best Practice Prompt Menu ...
  FMMT  Create/Modify Health Summary Type using Fileman
  HSSP  Update Health Summary Site parameters
  IPT  Update the Minor Procedures CPT Taxonomy
  MPT  Update the Major Procedures CPT Taxonomy
  PWH  Patient Wellness Handout Menu ...

Select Health Summary Maintenance Option: DF Delete Health Summary
Flowsheet

Select HEALTH SUMMARY FLOWSHEET NAME: TEST
SURE YOU WANT TO DELETE THIS FLOWSHEET? No// Y (Yes)
```

Figure 5-8: Example of deleting health summary flowsheet (DF)

5.16 Delete Health Summary Flowsheet Item (DI)

Use the DI option to delete a class of items for creating flowsheets. Items that have been deleted cannot be recovered. Follow these steps:

1. At the “Health Summary Maintenance Option” prompt, type **DI**.
2. At the “Select HEALTH SUMMARY FLOWSHEET ITEM NAME” prompt, specify the name of the health summary flowsheet item to be deleted, then press Enter.
3. At the ”SURE YOU WANT TO DELETE THIS FLOWSHEET ITEM?” prompt, type either **Y** (Yes) or **N** (No), then press Enter.

```
  IS   Inquire About a Health Summary Type
  HM   Health Maintenance Reminders ...
  PP   Print Health Maintenance Item Protocols
  LS   List Health Summary Types
  LC   List Health Summary Components
  LM   List Measurement Panel Types
  LF   List Health Summary Flowsheets
  LI   List Health Summary Flowsheet Items
  MS   Create/Modify Health Summary Type
  MM   Create/Modify Measurement Panel
  MF   Create/Modify Flowsheet
  MI   Create/Modify Flowsheet Item
  DS   Delete Health Summary Type


  DM   Delete Measurement Panel Definition
  DF   Delete Health Summary Flowsheet
  DI   Delete Health Summary Flowsheet Item
  HS   Generate Health Summary
  BP   Best Practice Prompt Menu ...
  FMMT  Create/Modify Health Summary Type using Fileman
  HSSP  Update Health Summary Site parameters
  IPT  Update the Minor Procedures CPT Taxonomy
  MPT  Update the Major Procedures CPT Taxonomy
  PWH  Patient Wellness Handout Menu ...

Select Health Summary Maintenance Option: DI Delete Health Summary
Flowsheet Item

Select HEALTH SUMMARY FLOWSHEET ITEM NAME: TEST
SURE YOU WANT TO DELETE THIS FLOWSHEET ITEM? No// Y (Yes)

Select HEALTH SUMMARY FLOWSHEET ITEM NAME:
```

Figure 5-9: Example of deleting a health summary flowsheet item (DI)

5.17 Generate Health Summary (HS)

Refer to Section 3.1, Generate Health Summary (HS) for detailed instructions. The prompts are the same.

5.18 Best Practice Prompt Menu (BP)

Refer to Section 8.0, Best Practice Prompt Menu, for detailed information about this option and its menu.

5.19 Create/Modify Health Summary Type using FileMan (FMMT)

Use the FMMT option to edit a health summary type line-by-line *without* accessing the Create/Modify Health Summary Type (MS) option. Refer to Section 4.13 for detailed instructions. The prompts are the same.

5.20 Update Health Summary Site Parameters (HSSP)

Refer to Section 4.14, Update Health Summary Site Parameters (HSSP), for detailed instructions. The prompts are the same.

5.21 Update the Minor Procedures CPT Taxonomy (IPT)

Use the IPT option to update the list of CPT codes to be included in the History of Minor Surgery component of the Health Summary. This taxonomy should contain only CPT codes for procedures/surgeries that would be on the minor surgery section of the Health Summary. Follow these steps:

1. At the “Health Summary Maintenance Option” prompt, type **IPT**.
2. At the “Press enter to continue” prompt, press Enter.

The Taxonomy Update screen displays.

```
TAXONOMY UPDATE                                   Mar 04, 2008 12:30:56  Page: 1 of 1

Updating the APCH HS MINOR PROCEDURE CPTS taxonomy
1) 10000 -17999

Enter ?? for more actions
A Add Item    R Remove Item   Q Quit
Select Action:+//
```

Figure 5-10: Example of updating minor procedures CPT Taxonomy (IPT)

- Type **A** (Add Item) to enter another CPT.
- Type **R** (Remove) to remove a CPT code from the list. To do this, type a minus sign (–) before the code. For example, to remove Code 56001 from this taxonomy, type **-56001** at the “Enter Another CPT” prompt. The application confirms that the specified code will be removed.
- Type **Q** (Quit) to leave the screen and return to the “Select Health Summary Maintenance Option” prompt.

5.22 Update the Major Procedures CPT Taxonomy (MPT)

Use the MPT option to update the list of CPT codes to be included in the History of Surgery component of the Health Summary. This taxonomy should contain only CPT codes for procedures/surgeries that should be on the History of Surgery section of the Health Summary. Follow these steps:

1. At the “Health Summary Maintenance Option” prompt, type **MPT**.
2. At the “Press enter to continue” prompt, press Enter to display the Taxonomy Update screen.

```
TAXONOMY UPDATE                                    Mar 01, 2008 12:29:40 Page: 1 of 1
Updating the APCH HS MAJOR PROCEDURE CPTS taxonomy
1) 19000 -29086
2) 29131 -29455
3) 29520 -29550
4) 29590 -29590
5) 29705 -36299
6) 36500 -36598
7) 36800 -51700

8) 51703 -59015
9) 59030 -59420
10) 59500 -59501
11) 59514 -59514
12) 59520 -59620
13) 59800 -69155
14) 69300 -69990
15) 93501 -93581
16) 97597 -97602

Enter ?? for more actions
A Add Item    R Remove Item   Q Quit
Select Action:+//Q
```

Figure 5-11: Example of updating major procedures CPT Taxonomy (MPT)

- Type **A** (Add Item) to enter another CPT.
- Type **R** (Remove) to remove a CPT code from the list. To do this, type a minus sign (**–**) before the code. For example, to remove Code 56001 from this taxonomy, type **-56001** at the “Enter Another CPT” prompt and press Enter. The application confirms that the specified code will be removed.
- Type **Q** (Quit) to leave the screen and return to the “Select Health Summary Maintenance Option” prompt.

6.0 Patient Wellness Handout Menu

The Patient Wellness Handout (PWH) provides patients with access to some of the information in their medical record, such as immunizations due, weight, height, BMI, blood pressure, allergies, and current medications.

The PWH combines features of RPMS with the concepts developed by the Agency for Healthcare Research and Quality's (AHRQ's) Putting Prevention into Practice program. These features address the Institute of Medicine's (IOM's) 10 rules of patient-centered care, and empower patients to improve their health and satisfaction with medical services.

The PWH can be printed in a variety of settings and at various times during the patient visit. Evaluate your processes and uses for the PWH to determine when it will be most effective at your site.

If printed before a patient visit, the PWH will populate information using the patient's most recent previous visit data.

To access PWH functions, go to the main Health Summary menu. As shown below, MPWH is the option to access the main PWH menu, which includes suboptions to update the default PWH that prints for a site, print an AAP, create/modify a non-standard PWH, and run a report on the number of PWHs given.

Option PWH below is the option to quickly generate a PWH.

```
                 ************************************
                 **        IHS Health Summary      **
                 ************************************
                            Version 2.0

                            DEMO HOSPITAL


 HS   Generate Health Summary
 BRHS Browse Health Summary
 MHS  Generate Multiple Health Summaries
 CRHS Health Summary Displaying CMS Register(s)
 INHS Health Summary for Inactive Patient
 BLD  Build Health Summary ...
 GSUP Generate a Health Summary Supplement
 HSM  Health Summary Maintenance ...
 MPWH Patient Wellness Handout Menu ...
 PWH  Generate a Patient Wellness Handout

Select Health Summary Menu Option:
```

Figure 6-1: Example of PWH menu options in the main Health Summary menu

6.1 Available PWH Components

A PWH consists of one or more components. A user with the appropriate security key can create and save multiple PWH types that include components of their choosing to use at a later date for other patients.

The available components are:

- Activity Level
- Allergies
- Anticoagulation
- Appointments
- Ask Me 3 Questions
- Blood Pressure
- Cancer Screening
- Cholesterol
- Demographics
- Diabetes Care
- Diabetes Screening
- Education Handouts
- Family History
- Healthcare Goals
- Height/Weight/BMI
- HIV Screening
- Immunizations Due
- Immunizations Received
- Medications (Active Only)
- Medications (Active and Recently Expired)
- Patient Goals
- Pediatric Screening
- Problem List
- Procedures
- Recent BP History
- Recent Lab Results

- Recent Weight History

6.2 PWH Types

There are two nationally-standardized PWH types: (1) Adult Regular and (2) Medication Reconciliation.

6.2.1 Standardized Type: Adult Regular

The Adult Regular type displays data from all available components. The components display in the following order:

- Demographics
- Height/Weight/BMI
- Medications (Active Only) or Medications (Active and Recently Expired)
- Blood Pressure
- HIV Screening
- Allergies
- Immunizations Due
- Immunizations Received
- Cholesterol
- Diabetes Care
- Cancer Screening
- Transparency Measures
- Healthcare Goals
- Activity Level
- Ask Me 3 Questions

6.2.2 Standardized Type: Medication Reconciliation

The Medication Reconciliation type displays data from the following components: (1) Allergies and (2) Medications.

6.2.3 Customized Type

As mentioned previously, a user with the appropriate security key can create and save multiple PWH types that include components of their choosing to use at a later date for other patients.

7.0 Options on the Patient Wellness Handout Menu

Use the MPWH option to access the options in the PWH menu.

At the “Select Health Summary Menu Option” prompt, type **MPWH** to display the following menu options:

```
 PWH Generate a Patient Wellness Handout
 DEF Update Default PWH for a Site
 AAP Print Asthma Action Plan
 MPWT Create/Modify Patient Wellness Type
 TPWH Number of PWHs Given to Patients Report

Select Patient Wellness Handout Menu Option:
```

Figure 7-1: Options in the Patient Wellness Handout menu

Refer to Appendix H: for more information about the components.

7.1 Generate a Patient Wellness Handout (PWH)

Use the PWH option to generate a Patient Wellness Handout for a specified patient. Each time a PWH is generated, the log records the patient, the date, the location, and the user who generated the handout.

To generate a Patient Wellness Handout, follow these steps:

1. At the “Select Patient Wellness Handout Menu Option” prompt, type **PWH**.
2. At the “Select Patient Wellness Handout type” prompt, specify the patient wellness handout type. Type one of the following: **Adult Regular:** contains all 14 components or **Medication Reconciliation:** contains Medications and Allergies.
3. At the “Select Patient” prompt, specify the patient to use for the handout, then press Enter.
4. At the “Select one of the following” prompt, type either **P** (print output) or **B** (browse output on screen).

Below is an example.

```
   PWH  Generate a Patient Wellness Handout
   DEF  Update Default PWH for a Site
   AAP  Print Asthma Action Plan
   MPWT  Create/Modify Patient Wellness Type
   TPWH  Number of PWHs Given to Patients Report

 Select Patient Wellness Handout Menu Option: PWH Generate a Patient Wellness Handout
```

```
             *** Patient Wellness Handout ***
```

```
Select Patient Wellness Handout type: ADULT REGULAR//

Select patient: SMITH,LEE

   Select one of the following:

     P     PRINT Output
     B     BROWSE Output on Screen

Do you wish to: P// RINT Output
DEVICE: HOME//  VT  Right Margin: 80//

***CONFIDENTIAL PATIENT INFORMATION [XXX] Dec 11, 2008 ***

SMITH, LEE HRN: 1122     CHEROKEE INDIAN HOSPITAL
P.O. BOX 0000         SOMEWHERE, NM 11111
555-555-5555

Thank you for choosing DEMO HOSPITAL.
This handout is a new way for you and your doctor to look at your health.

_____________________________________________________________________
QUALITY OF CARE TRANSPARENCY REPORT CARD - This report looks at
5 quality measures. This report card enables you to compare your personal results to
those on the IHS Quality of Care website at: http://www.ihs.gov/transparency. Your
personal information is listed below.
Asthma Medication Status
This reports looks to see if you were prescribed a medicine for your asthma. You
were not prescribed any asthma medications this year. Talk to your doctor about what
asthma treatment, if any, is best for you.

Diabetes and BP Control
This section only reports on people who have diabetes. You do not have diabetes, so
you are not included in this report.

Diabetes and Glycemic (A1c) Control
This section only reports on people who have diabetes. You do not have diabetes, so
you are not included in this report.
Diabetes and LDL Control
This section only reports on people who have diabetes. You do not have diabetes, so
you are not included in this report.

Flu Shot (Influenza) Vaccine
This section only reports on people who are 50 years of age or older. You are
younger than 50, so you are not included in this report.

_____________________________________________________________________
CHOLESTEROL
Controlling your cholesterol can keep your heart and blood vessels healthy.

Your total cholesterol result was 242 mg/dL on Aug 16, 2001.
Your last LDL (bad cholesterol) result was 134 on Aug 16, 2001.
Your last HDL (good cholesterol) result was 83 on Aug 16, 2001.
Your last triglyceride result was 122 on Aug 16, 2001.

No recent cholesterol is on file. You should have your cholesterol rechecked at your
next visit.

*** END CONFIDENTIAL PATIENT INFORMATION [XXX] Dec 11, 2008 ***
```

```
Enter ?? for more actions >>>
+ NEXT SCREEN   - PREVIOUS SCREEN  Q QUIT
Select Action: +//
```

Figure 7-2: Example output for Patient Wellness Handout (PWH)

The following actions can occur on the Output Browser screen:

- Type **Q** (Quit) to exit the Output Browser screen to return to the "Select Health Summary Menu Option" prompt.
- Type a plus sign (+) to display the next screen. This option is not available for the last screen.
- Type a minus sign (–) to display the previous screen. This option is not available for the first screen.

7.2 Update Default PWH for a Site (DEF)

Use the DEF option to set the default PWH for a site. Follow these steps:

1. At the "Select Patient Wellness Handout Menu Option" prompt, type **DEF**, then press Enter.
2. At the "Select PCC Master Control Site" prompt, type the location of the site, then press Enter.
3. At the "DEFAULT PAT WELLNESS HANDOUT" prompt, specify the name of the default handout.

```
  PWH  Generate a Patient Wellness Handout
  DEF  Update Default PWH for a Site
  AAP  Print Asthma Action Plan
  MPWT  Create/Modify Patient Wellness Type
  TPWH  Number of PWHs Given to Patients Report

Select Patient Wellness Handout Menu Option: DEF Update Default PWH
for a Site

This option is used to set the default Patient Wellness Handout
for a site.

Select PCC MASTER CONTROL SITE: DEMO HOSPITAL//  HEADQUARTERS WEST N
ON SERVICE UNIT    01    MN IHS    497
DEFAULT PAT WELLNESS HANDOUT: ADULT REGULAR//
```

Figure 7-3: Example Update Default PWH for a Site (DEF)

7.3 Print Asthma Action Plan (AAP)

Use the AAP option to produce an Asthma Action Plan that can be given to a patient.

At the "Select patient" prompt, specify the patient to be used.

1. At the “Red Zone Instruction” prompt, specify the RED ZONE Plan for this patient, including medication name(s) and instructions. Type one of the following: **B** (Display a Blank line for the Instruction to be Hand Written) or **N** (Enter a New Set of Red Zone Instruction). If there are existing instructions, the third option **E** (Use Existing Red Zone Instructions shown above) will display.
   - If the B option is used, the “Yellow Zone Instructions” prompt displays. If the N option is used, the “Enter Yellow Zone Instructions” prompt displays.
   - Specify the yellow zone instructions. After completing the instruction, the “Do you wish to” prompt displays; type either **P** (print) or **B** (browse).

```
  PWH  Generate a Patient Wellness Handout
  DEF  Update Default PWH for a Site
  AAP  Print Asthma Action Plan
  MPWT  Create/Modify Patient Wellness Type
  TPWH  Number of PWHs Given to Patients Report

Select Patient Wellness Handout Menu Option: AAP Print Asthma Action
Plan

            *** Print ASTHMA ACTION PLAN ***

This option will produce an Asthma Action Plan that can be given to
the patient.

Select patient: SMITH,JAMES

 SMITH,JAMES              M 10-01-1979 XXX-XX-1111 DEMO 1111
Patient's chart number is 1111


Please enter the RED ZONE Plan for this patient, including
medication name(s) and instructions.


   Select one of the following:

 B     Display a Blank line for the Instructions to be Hand Written
 N     Enter a New Set of Red Zone Instructions

Red Zone Instructions: B Display a Blank line for the Instructions
to be Hand Written

Please enter the YELLOW ZONE Plan for this patient, including
medication name(s) and instructions.


Yellow Zone Instructions: B Display a Blank line for the
Instructions to be Hand Written


   Select one of the following:
```

```
     P     PRINT Output
     B     BROWSE Output on Screen

Do you wish to: P// RINT Output
DEVICE: HOME//  VT  Right Margin: 80//

DEMO HOSPITAL                     Today's Date: Feb 09, 2010
Patient Name: SMITH,JAMES           Birth Date: Oct 01, 1979 Age: 30
_____________________________________________________________________
My Doctor:   Phone number:
  Address:  MN 56671
My Pharmacy: RED LAKE PHARMACY   Phone number: 555-5555
My Contact person: SMITH,JANE   Phone number:
_____________________________________________________________________

Asthma Triggers
No Triggers identified.

ASTHMA ACTION PLAN

  Your Personal Best Peak Flow: None documented; please discuss with
your provider at your next clinic visit.

Follow these steps to control your asthma.
**********************************************************************

RED ZONE - Need Medical Help!!

Enter RETURN to continue or '^' to exit
```

Figure 7-4: Example of printing the Asthma Action Plan (AAP)

7.4 Create/Modify Patient Wellness Type (MPWT)

Use the MPWT option to create a new or modify an existing PWH type. Follow these steps:

1. At the "Select HEALTH SUMMARY PWH TYPE NAME" prompt, specify the type of summary to view or print. Type one of the following: **Adult Regular** which contains all 14 components or **Medication Reconciliation** which contains Medications and Allergies. The application verifies the users' selection at the "NAME" prompt.
2. At the "LOCK" prompt, specify the lock used to create or modify the patient wellness type.

The application displays the wellness type specified. The ADULT REGULAR wellness type is shown in the following example.

```
                    DEMO HOSPITAL
```

```
  PWH  Generate a Patient Wellness Handout
  DEF  Update Default PWH for a Site
  AAP  Print Asthma Action Plan
  MPWT  Create/Modify Patient Wellness Type
  TPWH  Number of PWHs Given to Patients Report

Select Patient Wellness Handout Menu Option: MPWT Create/Modify Patient Wellness
Type


This option will allow you to create a new or modify an existing
Patient Wellness Handout type.


Select HEALTH SUMMARY PWH TYPE NAME: ADULT REGULAR
NAME: ADULT REGULAR//
LOCK: APCHZMGR//

DH  Display Handout   Q  Quit
Create/Modify PWH Type                          Nov 03, 2009 12:53:16   Page: 1 of 2
Patient Wellness Handout: ADULT REGULAR


STRUCTURE:
Order Component
10 HEIGHT/WEIGHT/BMI
20 MEDICATIONS
30 BLOOD PRESSURE
40 HIV SCREENING
50 ALLERGIES
Source for Allergy component: FROM BOTH ALLERGY TRACKING AND PROBLEM LIST
60 IMMUNIZATIONS RECEIVED
70 IMMUNIZATIONS DUE
75 CHOLESTEROL
80 DIABETES CARE
85 CANCER SCREENING
90 QUALITY OF CARE TRANSPARENCY REPORT CARD
+   Enter ?? for more actions
MS Modify Structure  PH Print Handout
DH Display Handout  Q Quit
Select Action:+//
```

Figure 7-5: Example of modifying an existing PWH type

4. To quit the screen, type **Q** (Quit) at the “Select Action” prompt.

The MS, DH, and PH actions in Figure 7-5 are described in the following sections.

7.4.1 Modify Structure (MS)

Use the Modify Structure (MS) option to add a new component by entering a new order number and component name. To remove a component from this PWH type, specify the component by name or order and then type the at sign (**@**) character.

7.4.2 Display Handout (DH)

Use the DH action to display a handout for a specified patient.

1. At the “Select Action” prompt, type **DH** to display the handout.

The following options can be used at the “Select Action: +//” prompt:

- Type **Q** (Quit) to exit the screen.
- Type a plus sign (+) (plus) to display the next screen. This option is not available for the last screen.
- Type a minus sign (–) (minus) to display the previous screen. This option is not available for the first screen.

7.4.3 Print Handout (PH)

Use the PH action to print the handout for a specified patient. Follow these steps:

1. At the “Select patient” prompt, specify the patient to use for the handout.
2. At the “Select one of the following” prompt, type either **P** (print output) or **B** (browse output on screen). The report will output.

At the “Enter RETURN to continue or ‘^’ to exit” prompt, you may:

- Press Enter to continue with the next page of the report.
- Type a caret (^) to exit the report and to return to the “Select Action” prompt.

7.5 Number of PWHs Given to Patients Report (TPWH)

The TPWH option produces a report that tallies the number of PWHs given to a patient. The tally can be based on handout type, location, date the handout was generated, and user/provider that generated the handout. Optionally, a list of patients receiving the handout can be produced. Follow these steps:

1. At the “Enter beginning Date of Patient Wellness Handout” prompt, type the beginning date of the date range.
2. At the “Enter ending Date of Patient Wellness Handout” prompt, type the ending date of the date range.
3. At the “Do you wish to run the report for a particular patient handout?” prompt, type **Y** (Yes) or **N** (No). If **Y** (Yes) was typed, the “Enter Patient Wellness Type” prompt will display.
4. At the “Do you wish to run the report for a particular location?” prompt, type **Y** (Yes) or **N** (No). If the user typed **Y**, the “Enter Location” prompt will display.

5. At the “Do you wish to run the report for a particular provider/user?” prompt, type **Y** (Yes) or **N** (No). If the user typed **Y**, the “Enter Provider” prompt will display.
6. At the “Do you want a list of patients” prompt, type **Y** (Yes) or **N** (No).
7. At the “Do you wish to” prompt, type **P** (print output) or **B** (browse output on screen).

The application displays the Patient Wellness Handout Tally report.

```
This report will tally the number of Patient Wellness Handouts given
to patients. The user will be able to tally based on handout type,
location date the handout was generated and user/provider who
generated the handout. Optionally, the user can produce a list of
patients receiving the handout.


Enter beginning Date of Patient Wellness Handout: T-200 (JUL 10,
2009)


Enter ending date of Patient Wellness Handout: T (JAN 26, 2010)

Do you wish to run the report for a particular patient handout? N//
YES

Enter Patient Wellness Type: ADULT REGULAR

Enter Patient Wellness Type:

Do you wish to run the report for a particular location? N// YES

Enter Location: DEMO DEMO HOSPITAL   HEADQUARTERS WEST NON SERVICE
UNIT 01    MN IHS  497

Enter Location:

Do you wish to run the report for a particular provider/user? N//
YES

Enter Provider: SMITH, JANE  JAS

Enter Provider:


Do you want a list of patients? N// YES

  Select one of the following:

   N   Name of Patient
   P   Provider/User
   L   Location
   T   Type of Handout
   D   Date Handout Generated
```

```
How do you want the list sorted: N// ame of Patient

  Select one of the following:

   P   PRINT Output
   B   BROWSE Output on Screen

Do you wish to: P// RINT Output
DEVICE: HOME// VT Right Margin: 80//


***** CONFIDENTIAL PATIENT INFORMATION [LAF] Jan 26, 2010 *****
                        PATIENT WELLNESS HANDOUT TALLY
                     Date Range: Jul 10, 2009 - Jan 26, 2010
Handout Types Selected: ADULT REGULAR
Locations Selected: DEMO HOSPITAL
Providers/Users Selected: SMITH, JANE
-------------------------------------------------------------------
LOCATION            #
-------------------------------------------------------------------

DEMO HOSPITAL            41

 ADULT REGULAR           32

  SMITH,JANE            16


Enter RETURN to continue or '^' to exit:
```

Figure 7-6: Example of prompts for and output of the Number of PWHs Given to Patients Report (TPWH)

The following options can be used on the Output Browser screen:

- Type **Q** (Quit) to exit the Output Browser screen and return to the “Select Health Summary Menu Option” prompt.
- Type a plus sign (+) to display the next screen. This option is not available for the last screen.
- Type a minus sign (–) to display the previous screen. This option is not available for the first screen.

8.0 Health Maintenance Reminders

The PCC Health Maintenance Reminder (HMR) system is designed to assist healthcare providers with addressing preventive and early detection healthcare measures. The system monitors a set of procedures (such as tuberculin skin tests, examinations, and laboratory tests) that should be performed for each member of a population at various stages of life. The recommended timing for these procedures is a function of the patient's age and sex. These standards were developed by IHS senior clinicians and field health groups throughout the IHS organization.

The general criteria used for inclusion of items in the HMR system are as follows:

- Screening is for problems that are prevalent and medically significant among all or certain groups of American Indians and Alaska Natives (AI/ANs).
- The screening tests are considered to be effective.
- If a problem is detected, treatment can be provided.
- The tests can be accomplished by the IHS at current staffing levels without adversely affecting other patient needs, services, or programs at the facility level.
- For children, the system generally follows the recommendations of the American Academy of Pediatrics.

The criteria for the PCC HMR system have been adopted for service-wide use by the IHS. For an individual patient at a given visit, the HMR procedures should be viewed as recommendations or suggestions to providers of care, not as directives. Often a patient's condition will negate performing certain health maintenance tests or examinations. Certain procedures may not be considered appropriate for a specific population group. These items can be removed from the system at the direction of the Area Office. The procedures suggested by the HMR system should in no way constrain healthcare providers from performing additional tests that are warranted.

Because patients rarely receive certain types of services exactly when they are due, the PCC system attempts to reasonably apply these standards. For instance, the IHS recommends that children have a urinalysis at age five. This does not mean that the Health Summary will prompt the provider for a urinalysis at age five if this patient had a urinalysis at age 4 years 11 months. The prompt will appear when the child turns five if there is no record of a urinalysis in the database. The lack of this record in the database does not necessarily mean that the child never had a urinalysis, only that the result was never entered into the system. The prompt will also appear if the child's last urinalysis occurred before age three.

The Health Maintenance Reminder menu can be accessed by typing **HM** and pressing Enter at the "Select Health Summary Maintenance Option" prompt on the Health Summary Maintenance menu.

Below are the options on the Health Maintenance Reminder menu.

```
                              ***************************************
                              **          IHS Health Summary       **
                              ** Health Maintenance Reminder Menu **
                              ***************************************
                                  IHS PCC Suite Version 2.0

                                        DEMO HOSPITAL


 OD  Display One Health Maintenance Reminder Desc
 AI  Activate/Inactivate a Health Maintenance Reminder
 LHMR List Health Maintenance Reminders by Status
 LS  Add/Modify Locally Defined HM Reminder Criteria
 PR  Print Health Maintenance Item Protocols

Select Health Maintenance Reminders Option:
```

Figure 8-1: Options in the Health Maintenance Reminder menu

8.1 Display One Health Maintenance Reminder Desc (OD)

The Display One Health Maintenance Reminder Desc (OD) menu option allows the user to view the trigger logic of a specific HMR. Follow these steps:

1. At the “Select Health Maintenance Reminders Option” prompt, type **OD** to display the Health Reminder Display menu.

```
HEALTH REMINDER DISPLAY      Nov 02, 2009 12:36:40   Page: 1 of 1

1) ADULT MMR 1-DOSE VER 15) DOMESTIC VIOLENCE/IP 29) OSTEOPOROSIS SCREENI
2) ADULT MMR 2-DOSE VER 16) EPSDT Screening  30) PAP SMEAR
3) ALCOHOL USE SCREENIN 17) FALL RISK ASSESSMENT 31) PELVIC EXAM
4) ANMC DEPRESSION SCRE 18) HCT/HGB    32) PHYSICAL EXAM
5) ASSESSMENT OF FUNCTI 19) HEAD CIRCUMFERENCE 33) PNEUMOVAX
6) BLOOD PRESSURE   20) HEARING TEST   34) PPD - TUBERCULOSIS
7) BREAST EXAM   21) HEIGHT    35) RECTAL
8) CHLAMYDIA SCREENING 22) HIV SCREENING   36) TD-ADULT
9) CHOLESTEROL   23) IMMUNIZATIONS   37) TOBACCO USE SCREENIN
10) COLORECTAL CA SCRN-F 24) INFLUENZA    38) TONOMETRY
11) COLORECTAL CA-SCOPE/ 25) LDL Elevated for IHD 39) URINALYSIS
12) DENTAL EXAM   26) LDL Screening for IH 40) VISUAL ACUITY EXAM
13) DEPRESSION SCREENING 27) MAMMOGRAM    41) WEIGHT
14) DIABETES SCREENING 28) NEWBORN HEARING SCRE

   Enter ?? for more actions
S Select Item   A Display All Items Q Quit
Select Action: +//
```

Figure 8-2: Options in the Health Reminder Display menu

Type **Q** (Quit) to return to the “Select Health Maintenance Reminders Option” prompt. Otherwise, use the other actions to continue.

2. At the “Select Action” prompt, type **S** (Select Item) to select an item on the list or type **A** (Display All Items). If **A** is typed, all of the reminders descriptions and logic will display on the Output Browser screen.
3. At the “Which item(s)” prompt, specify the HMR number to display.

The Output Browser screen displays, showing information about the selected item. Figure 8-3 is an example of the Newborn Hearing Screen.

```
OUTPUT BROWSER                                  Nov 02, 2009 12:38:29   Page: 1 of 2
HEALTH MAINTENANCE REMINDERS DESCRIPTIONS

Reminder:   NEWBORN HEARING SCREEN
Status:   ACTIVE (ON)

Description:
 Default Status: On
 Category: Pediatric
 Denominator: All patients until age 1 with no documented hearing tests in
 both ears.

 Definition (Frequency): One time. This reminder will continue to appear
 for patients through age 1 year until the tests are documented for BOTH
 ears or age 1 is reached.

 LOGIC DETAIL:
 Newborn Hearing Screening:
 - Exam: V Exam 38 Newborn Hearing Screen (Right) AND 39 Newborn Hearing
 Screen (Left); must have both exam codes documented.
 - Diagnosis (ICD) Codes: V POV or Problem List: 389.00-389.9;
744.00-744.02; 794.15 (APCH Hearing Loss DXS)
 - Procedures (CPTs): V CPT 99431; 99435 (APCH Newbrn Hear Scrn CPTS) or
 92551; 92552; 92553; 92587; 92555; 92556; 92557; 92579; 92582; 92583;
 92585; 92586; 92590-92594; 92620-92621; 92630 (APCH Hearing Screen CPTS)
 - Procedures (ICD): V POV V72.1-V72.19.

 Site Configurable? No

Currently Defined Criteria in Use at this Facility:
<<< No Local Criteria defined >>>

Currently defined on the following summary types:
    ALL REMINDERS
    NUTRITION TEST
+   Enter ?? for more actions           >>>
+ NEXT SCREEN   - PREVIOUS SCREEN  Q QUIT
Select Action: +//
```

Figure 8-3: Example description of the selected HMR

- Type **Q** (Quit) to exit the Output Browser screen to return to the “Select Health Maintenance Reminders Option” prompt.
- Type a plus sign (+) to display the next screen. This option is not available for the last screen.
- Type a minus sign (-) to display the previous screen. This option is not available for the first screen.

8.2 List Health Maintenance Reminders by Status (LHMR)

Use the LHMR option to list the health maintenance reminders with status. Follow these steps:

1. At the “List which set of Reminders” prompt, type one of the following: **A** (active reminders), **I** (inactive reminders), or **B** (both active and inactive reminders).
2. At the “How would you like the list sorted” prompt, type one of the following: **C** (by category), **N** (by name), or **S** (by status). Type **S** to display the following fields: Reminder Title, Category, and Summary Types.
3. At the “Do you wish to” prompt, type either **P** (print output) or **B** (browse output on screen) to display the reminders by status report.

```
SJT                  Page 1
         DEMO HOSPITAL
     HEALTH SUMMARY HEALTH MAINTENANCE REMINDERS
      BOTH ACTIVE AND INACTIVE REMINDERS
-------------------------------------------------------------------
REMINDER     CATEGORY   STATUS   HEALTH SUMMARY TYPES
-------------------------------------------------------------------
ALCOHOL USE SCREENING  BEHAVIORAL HEAL ACTIVE (ON) ADULT REGULAR
               DIABETES STANDARD
               EMPLOYEE
               HEALTH MAINTENANCE
               ALL REMINDERS
               TEST
ANMC DEPRESSION SCREEN SC BEHAVIORAL HEAL INACTIVE (OFF) LORI
DEPRESSION SCREENING  BEHAVIORAL HEAL ACTIVE (ON) ALL REMINDERS
               TEST
DOMESTIC VIOLENCE/IPV SCR BEHAVIORAL HEAL ACTIVE (ON) ADULT REGULAR
               DIABETES STANDARD
               HEALTH MAINTENANCE
               ALL REMINDERS
COLORECTAL CA SCRN-FOBT CANCER-RELATED ACTIVE (ON) HEALTH
MAINTENANCE
               ALL REMINDERS
               NUTRITION
COLORECTAL CA-SCOPE/XRAY CANCER-RELATED ACTIVE (ON) HEALTH
MAINTENANCE
               ALL REMINDERS
               NUTRITION
               LORI
MAMMOGRAM     CANCER-RELATED ACTIVE (ON) ADULT REGULAR
               DIABETES STANDARD
               EMPLOYEE
               HEALTH MAINTENANCE
               ALL REMINDERS

Enter RETURN to continue or '^' to exit:
```

Figure 8-4: Sample of the Health Maintenance Reminders by Status report (LHMR)

8.3 Activate/Inactivate a Health Maintenance Reminder (AI)

The AI option can inactivate or activate a specified HMR. If an HMR is active, it can be added to a Health Summary and, if its conditions are met, the appropriate reminder will display in the Health Summary. Follow these steps:

1. At the "Select Health Maintenance Reminders Option" prompt, type **AI**.
2. At the "Select Health Reminder to Activate/Inactivate" prompt specify the name of the reminder that will change status.

Below is an example of prompts for the Dental Exam Reminder.

```
Reminder:   DENTAL EXAM
Status:   INACTIVE (OFF)

Description:
 Default Status: Off
 Denominator: All patients, all ages
 Definition (Frequency): Annually

 LOGIC DETAIL:
 Dental Exam:
 - V Dental ADA code 0000 or 0190
 - V Exam or Refusal: 30 Dental Exam
 - CHS visit with any ADA code

 Site Configurable? Yes: sex, age range and frequencies

Currently Defined Criteria in Use at this Facility
<<< No local criteria defined. >>>

STATUS: INACTIVE (OFF)//
```

Figure 8-5: Example of Dental Exam Reminder Status set to inactive.

3. At the "STATUS" prompt, press Enter to accept the default value of INACTIVE (OFF) or type **A** (Active) to change the default value.

8.4 Add/Modify Locally Defined HM Reminder Criteria (LS)

The LS option adds or modifies specified locally defined reminder criteria (sex, age ranges, and frequencies for the health reminder). Follow these steps:

1. At the "Select Health Maintenance Reminders Option" prompt, type **LS**.
2. At the "Select Health Reminder to Modify" prompt, specify the name of the health reminder to add or modify.

The application displays information about the reminder on the APCH MODIFY HMR screen.

```
APCH MODIFY HMR                                    Dec 09, 2008 16:24:15 Page: 1 of 2
Modify Health Maintenance Reminder Criteria


Reminder:   HEARING TEST
Status:   ACTIVE (ON)
Description:
 Default Status: On
 Denominator: All patients at age 4 with no documented hearing test from ages 3 to 4
years.
 Definition (Frequency): One time. This reminder will continue to appear for
patients through age 7 years, until the test is documented.

 LOGIC DETAIL:
 Hearing Test:
 - Exam Codes: V Exam 17-HEARING (Inactive), 23-AUDIOMETRIC (Inactive),
 24-AUDIOMETRIC THRESHOLD (Inactive)
 - Screening Diagnosis (ICD Codes): V POV V72.11, V72.19
 - Measurements: V Measurement HEARING or AUDIOMETRY
+   Enter ?? for more actions
M Modify Criteria  Q Quit
Select Action: +//
```

Figure 8-6: Example of adding/modifying locally-defined criteria (LS)

Type **Q** (Quit) to quit the APCH MODIFY HMR screen and return to the “Select Health Maintenance Reminders Option” prompt.

The user can add a new sex, age range, frequency combination, or edit an existing item for the selected Best Practice Prompt.

The responses to the following prompts are required. At any prompt the user can type a caret (^) to exit.

1. At the “Select Action” prompt, type **M** (Modify) and press Enter.
2. At the “Do you wish to ADD some?” prompt, type **Y** (Yes) to add information.
3. At the “Select one of the following” prompt, type of the following: **F** (Female), **M** (Male), or **B** (Both).
4. At the “Enter Minimum Age” prompt, specify the minimum age in the age range. It must be typed in the following format: 1Y, 2M, 30D, 10Y, where Y = years, M = months and D = Days.
5. At the “Enter Maximum age” prompt, specify the maximum age in the age range. It must be typed in the following format: 1Y, 2M, 30D, 10Y, where Y = years, M = months and D = Days.
6. At the “Enter the frequency for Both Genders” prompt, specify the frequency in the form: 2Y for every 2 years, 3M for every 3 months, etc. (The prompt varies according to what was typed at the “Select one of the following” prompt).

The following is an example of the prompts that follow.

```
The following will be added:
  BOTH GENDERS, ages 45 years to 88 years reminder due every 2 years
Everything okay? Do you wish to continue and add it? Y// n NO



You may add a new sex, age range, frequency combination or edit and
existing
one for the HEARING INQUIRY reminder.

No local criteria currently defined.

Do you wish to ADD some? Y//
```

Figure 8-7: Example of ending prompts for the APCH MODIFY HMR screen

8.5 Print Health Maintenance Item Protocols (PR)

The PR option displays or prints the description/logic of all Health Summary maintenance reminders. Follow these steps:

1. At the “Select Health Maintenance Reminders Option” prompt, type **LS**.
2. At the “Select one of the following” prompt, type either: **P** (print output) or **B** (browse output on screen).

The application displays the OUTPUT BROWSER screen.

```
OUTPUT BROWSER                                  Dec 09, 2008 16:39:30  Page: 1 of 76

_____________________________________________________________________


XXXT              Page 1
    DEMO HOSPITAL
 HEALTH SUMMARY HEALTH MAINTENANCE REMINDERS

-------------------------------------------------------------------

Reminder:   ADULT MMR 1-DOSE VERSION
Status:   INACTIVE (OFF)

Description:
 Default Status: Off
 Denominator: Patients with no documented MMR since age 1 year:
 1. Born in 1957 or later who are at least 18; OR
 2. Females who were born in 1957 or earlier AND are currently less than age 50
years (NOTE: no longer applicable)

+   Enter ?? for more actions    >>>

+ NEXT SCREEN   - PREVIOUS SCREEN  Q QUIT
Select Action: +//
```

Figure 8-8: Example the Output Browser screen for printing health maintenance item protocols (PR)

- Type **Q** (Quit) to exit the Output Browser screen to return to the “Select Health Maintenance Reminders Option” prompt.
- Type a plus sign (+) to display the next screen. This option is not available for the last screen.
- Type a minus sign (-) to display the previous screen. This option is not available for the first screen.

9.0 Best Practice Prompt Menu (BP)

The Best Practice Prompt Menu (BP) is accessed from the Health Summary Maintenance Menu, as shown below. (See Figure 9-1 BP menu option in bold type.)

```
                          ************************************
                          **        IHS Health Summary       **
                          ** Health Summary Maintenance Menu **
                          ************************************
                                IHS PCC Suite Version 2.0

                                     DEMO HOSPITAL


IS  Inquire About a Health Summary Type
HM  Health Maintenance Reminders ...
PP  Print Health Maintenance Item Protocols
LS  List Health Summary Types
LC  List Health Summary Components
LM  List Measurement Panel Types
LF  List Health Summary Flowsheets
LI  List Health Summary Flowsheet Items
MS  Create/Modify Health Summary Type
MM  Create/Modify Measurement Panel
MF  Create/Modify Flowsheet
MI  Create/Modify Flowsheet Item
DS  Delete Health Summary Type
DM  Delete Measurement Panel Definition
DF  Delete Health Summary Flowsheet
DI  Delete Health Summary Flowsheet Item
HS  Generate Health Summary
BP  Best Practice Prompt Menu ...
FMMT Create/Modify Health Summary Type using Fileman
HSSP Update Health Summary Site parameters
IPT Update the Minor Procedures CPT Taxonomy
MPT Update the Major Procedures CPT Taxonomy
```

Figure 9-1: Best Practice Prompt Menu option on the Health Summary Maintenance Menu

The options for the Best Practice Prompt Menu are shown below.

```
 OD  Display One Treatment Prompt Description
 AI  Activate/Inactivate a Treatment Prompt
 LS  Add/Edit Locally Defined Treatment Prompt Criteria
 PR  Print Treatment Prompt Protocols

Select Best Practice Prompt Menu Option:
```

Figure 9-2: Best Practice Prompt Menu options

9.1 Display One Best Practice Prompt Description (OD)

Use the OD option to display the descriptions of the current Best Practice Prompt. The OD option displays to the Best Practice Display screen.

```
BEST PRACTICE DISPLAY                          Nov 02, 2009 12:05:55   Page: 1 of 2

1) ANTICOAGULATION: ANT 21) CVD Highest Risk: No 41) CVD Known: Tobacco U
2) ANTICOAGULATION: DUR 22) CVD Highest Risk: No 42) CVD Significant Risk
3) ANTICOAGULATION: INR 23) CVD Highest Risk: No 43) CVD Significant Risk
4) ANTICOAGULATION: SAF 24) CVD Highest Risk: No 44) CVD Significant Risk
5) ANTICOAGULATION: SAF 25) CVD Highest Risk: No 45) CVD Significant Risk
6) ANTICOAGULATION: SAF 26) CVD Highest Risk: No 46) CVD Significant Risk
7) ASTHMA: ACTION PLAN 27) CVD Highest Risk: No 47) CVD Significant Risk
8) ASTHMA: ADD/INCREASE 28) CVD Highest Risk: Sm 48) CVD Significant Risk
9) ASTHMA: CONTROL CLAS 29) CVD Known: High BP 49) CVD Significant Risk
10) ASTHMA: FLU SHOT  30) CVD Known: High LDL 50) CVD Significant Risk
11) ASTHMA: INCREASED RI 31) CVD Known: High TG 51) CVD Significant Risk
12) ASTHMA: PRIMARY CARE 32) CVD Known: Low HDL 52) CVD Significant Risk
13) ASTHMA: SEVERITY CLA 33) CVD Known: No ACEI/A 53) CVD Significant Risk
14) CVD At Risk: Missing 34) CVD Known: No ASA/An 54) CVD Significant Risk
15) CVD At Risk: No ASA/ 35) CVD Known: No Beta B 55) HEARING INQUIRY
16) CVD Highest Risk: Hi 36) CVD Known: No Exerci 56) RUBELLA IMMUNIZATION
17) CVD Highest Risk: Hi 37) CVD Known: No LDL  57) STRABISMUS/AMBLYOPIA
18) CVD Highest Risk: Hi 38) CVD Known: No Nutrit
19) CVD Highest Risk: Hi 39) CVD Known: No Recent
+   Enter ?? for more actions
S Display One   A Display All   Q Quit
Select Action:+//
```

Figure 9-3: Example Best Practice Display screen

To quit the current screen, type **Q** (Quit) at the “Select Action” prompt.

The following describes the other actions that for the Best Practice Display screen.

9.1.1 Display One (S)

Use the S action to display information (treatment prompt name, status, description, and criteria) about a specified Best Practice item.

1. At the “Select Action” prompt, type **S** (Display One).
2. At the “Which item(s)” prompt, specify the number of the item to display.

The following shows an example of the Anticoagulation: Safety Measure: CBC best practice prompt information that display in the Output Browser screen:

```
OUTPUT BROWSER                                 Nov 02, 2009 12:12:29   Page: 1 of 2
BEST PRACTICE PROMPTS DESCRIPTIONS

Best Practice Prompt: ANTICOAGULATION: SAFETY MEASURE: CBC
Status:    ACTIVE (ON)

Description:
 Safety Measure: Complete Blood Count (CBC)
```

```
 Clnical Guidelines recommend that patients on Anticoagulation therapy
 have a CBC annually. A CBC is defined as CPT Codes: 85025-85027 [BGP CBC
 CPT]; LOINC codes contained in [BGP CBC LOINC]; [BGP CBC TESTS]


Best Practice Prompt Text:
No CBC: A Complete Blood Count (CBC) is recommended annually for patients
 on Warfarin. The last CBC was reported on |ACCBCDT|.

Currently Defined Criteria in Use at this Facility:
<<< No Local Criteria defined >>>

Currently defined on the following summary types:
******************************************************************************
   Enter ?? for more actions           >>>
+ NEXT SCREEN   - PREVIOUS SCREEN  Q QUIT
Select Action: +//
```

Figure 9-4: Example of the “Anticoagulation: Safety Measure:CBC best practice” prompt information display

- Type **Q** (Quit) option to exit the window.
- Type a plus sign (+) to display the next screen. This option is not available for the last screen.
- Type a minus sign (-) to display the previous screen. This option is not available for the first screen

The following shows the information for Anticoagulation: Duration of Anticoagulation Therapy

```
OUTPUT BROWSER                                   Nov 02, 2009 12:25:23   Page: 1 of 2
BEST PRACTICE PROMPTS DESCRIPTIONS

Best Practice Prompt: ANTICOAGULATION: DURATION OF ANTICOAG THERAPY
Status:    ACTIVE (ON)

Description:
 Duration of Anticoagulation Therapy:
 It is recommended that patients who are on anti-coagulation therapy have
 a Duration of Anticoagulation Therapy established for them by their
 provider. The options include: 3 months; 6 months; 12 months or
 Indefinitely. This can be reassessed periodically based on the patient's
 need for continuing therapy. Re-establishing the Duration of
 Anticoagulation Therapy initiates a re-calculation of the
 Anticoagulation Therapy End Date.

Best Practice Prompt Text:
 No Duration of Anticoagulation Therapy: This patient is on Warfarin and
 a Duration of Anticoagulation Therapy is not documented.


Currently Defined Criteria in Use at this Facility:
<<< No Local Criteria defined >>>

Currently defined on the following summary types:

******************************************************************************
```

```
+   Enter ?? for more actions           >>>
+ NEXT SCREEN   - PREVIOUS SCREEN  Q QUIT
Select Action: +//
```

Figure 9-5: Example display of the Anticoagulation: Duration of Anticoagulation Therapy display information

9.1.2 Display All (A)

Use the A action to display the descriptions for all Best Practice prompts.

Below is a sample of the first page of the output.

```
OUTPUT BROWSER                                    Dec 09, 2008 15:01:43 Page: 1 of 24
BEST PRACTICE PROMPTS DESCRIPTIONS


Best Practice Prompt: ASTHMA: ACTION PLAN
Status:    ACTIVE (ON)

Description:
 Default Status: On
 Denominator: Patients with asthma who do not have a documented Action
 (Management) Plan in the past year. Asthma defined as:
 1. any Asthma Severity ever of 2, 3 or 4; OR
 2. iCare active Asthma tag; OR
 3. at least 3 instances of asthma primary diagnosis in the past 6 months.
 4. last documented asthma control status "not well controlled" or "very poorly
controlled"; OR
 5. history of asthma exacerbation in the past year; OR
 6) at least one ER or Urgent Care visit in the past year with a primary diagnosis
of asthma.

 Definition (Frequency): Annually

+   Enter ?? for more actions >>>
+ NEXT SCREEN   - PREVIOUS SCREEN  Q QUIT
Select Action: +//
```

Figure 9-6: Example of the Display All action, Page 1

- Type **Q** (Quit) to exit the window.
- Type a plus sign (+) to display the next screen. This option is not available for the last screen.
- Type a minus sign (-) to display the previous screen. This option is not available for the first screen

9.2 Activate/Inactivate a Treatment Prompt (AI)

Use the AI option to inactivate or activate a Best Practice prompt.

If a Best Practice prompt is active, it can be added to a Health Summary and, if its conditions are met, the appropriate prompt will display in the Health Summary.

To activate or inactivate a treatment prompt, follow these steps:

1. At the “Select Best Practice Menu Option” prompt, type **AI**.
2. At the “Select Best Practice Prompt to Activate/Inactivate” prompt, specify the name of the treatment prompt whose status the user wants to change.
3. The application displays the description and logic for the selected Best Practice prompt.

```
Status:    ACTIVE (ON)

Description:
 Default Status: On
 Denominator: Patients with asthma who do not have an influenza
 immunization documented during THIS flu season. Asthma defined as:
 1. any Asthma Severity ever of 2, 3 or 4; OR
Press return to continue:

 2. iCare active Asthma tag; OR
 3. at least 3 instances of asthma primary diagnosis in the past 6
months;
 OR
 4. current prescription for inhaled corticosteroids

 Definition (Frequency): Annually during the months of September
through March only

 LOGIC DETAIL:
 Asthma Diagnosis:
 - Diagnosis (ICD Codes) (not on same day, Primary dx only, and
Service Category A or H only): V POV 493.00-493.92 (BGP ASTHMA DXS
taxonomy)
 - Asthma Severity (Problem List Classification: category Asthma: 2-
mild persistent, 3-moderate persistent, 4-severe persistent
 - Active Asthma tag (iCare): Status Proposed or Accepted

 Inhaled Corticosteroids:
 - Site defined Medications: V Medications in BAT ASTHMA INHALED
STEROIDS taxonomy
 - NDC (National Drug Codes): V Medications as predefined in BAT
ASTHMA INHLD STEROIDS NDC taxonomy
Press return to continue:

 Best Practice Prompt Text:
 It is recommended that all asthma patients receive a flu shot. If
this patient has asthma (as documented on [most recent visit date
with asthma POV]) consider giving this patient a flu shot per
protocol during the season.


 Site Configurable? No.
```

```
Best Practice Prompt Text:
 It is recommended that all asthma patients receive a flu shot. If
this patient has asthma (as documented on |ASFS1|) consider giving
this patient a flu shot per protocol during the season.

Currently Defined Criteria in Use at this Facility
<<< No local criteria defined. >>>

STATUS: ACTIVE (ON)//
```

Figure 9-7: Example output for activating or inactivating a selected Best Practice prompt

4. At the “Status: Active (ON)” prompt either press Enter to accept the default value (ON) or type **AI** to use the Active/ Inactive option.

9.3 Add/Edit Defined Treatment Prompt Criteria (LS)

Use the LS option to specify sex, age ranges, and frequencies for an HMR.

Follow these steps:

1. At the “Select Best Practice Menu Option” prompt, type **LS**.
2. At the “Select Best Practice Prompt to Modify” prompt, specify the name of the treatment prompt to modify.

The Modify TP Criteria screen displays.

```
MODIFY TP CRITERIA                                Dec 09, 2008 15:31:22 Page: 1 of 2
Modify Best Practice Prompt Criteria


Best Practice PrompHEARING INQUIRY:
Status:   ACTIVE (ON)

Description:
 Default Status: On
 Denominator: All patients ages 65 and older.

 Definition (Frequency): N/A. This prompt appears routinely once the patient is age
65.
 Best Practice Prompt Text:
 Patient is over 64 years old. Consider inquiring about hearing
 difficulties at least every 2 years.

 Site Configurable? Yes: ages only.

+   Enter ?? for more actions
M Modify Criteria  Q Quit
Select Action:+//
```

Figure 9-8: Example of adding/editing treatment prompt criteria

3. Type **Q** (Quit) to quit the Modify TP Criteria screen and return to the “Select Action” prompt on the Best Practice Display screen.

4. Type **M** (Modify Criteria) to modify criteria such as sex, age, frequency or to edit an existing item at the “Select Action” prompt.
5. The application will display a message asking the user if he/she wants to add information. Type **N** (No) to leave the modify criteria process or type **Y** (Yes) to continue.

The responses to the following prompts are required otherwise, at a prompt, type a caret (^) to exit.

6. At the “Select one of the following” prompt, type one the following: **F** (female), **M** (male), or **B** (both).
7. At the “Enter Minimum Age” prompt, specify the minimum age in the age range in the following format: 1Y, 2M, 30D, 10Y, where Y = years, M = months, and D = days.
8. At the “Enter Maximum age” prompt, specify the maximum age in the age range in the following format: 1Y, 2M, 30D, 10Y, where Y = years, M = months, and D = days.
9. At the “Enter the frequency for Both Genders” prompt, specify the frequency in the following format: 2Y for every 2 years, 3M for every 3 months, etc. The prompt varies according to the response at the “Select one of the following” prompt.

Below shows an example of the prompts that follow:

```
The following will be added:

  BOTH GENDERS, ages 45 years to 88 years reminder due every 2 years
Everything okay? Do you wish to continue and add it? Y// n NO

You may add a new sex, age range, frequency combination or edit and
existing
one for the HEARING INQUIRY reminder.

No local criteria currently defined.
Do you wish to ADD some? Y//
```

Figure 9-9: Example of the prompts that confirm the changes to the treatment prompt criteria

9.4 Print Treatment Prompt Protocol (PR)

Use the PR option to display or print the description/logic of all Health Summary Best Practice prompts.

Follow these steps:

1. At the “Select Best Practice Menu Option” prompt, type **PR**.

2. At the “Select one of the following” prompt, type one the following: **P** (print output) or **B** (browse output on screen).

Below is an example Output Browser screen.

```
OUTPUT BROWSER                                  Dec 09, 2008 15:51:15 Page: 1 of 24


XXX              Page 1
     DEMO HOSPITAL
   HEALTH SUMMARY HEALTH MAINTENANCE BEST PRACTICE PROMPTS

-----------------------------------------------------------------

Best Practice Prompt: ASTHMA: ACTION PLAN
Status:    ACTIVE (ON)

Description:
 Default Status: On
 Denominator: Patients with asthma who do not have a documented Action (Management)
Plan in the past year. Asthma defined as:
 1. any Asthma Severity ever of 2, 3 or 4; OR
 2. iCare active Asthma tag; OR
+   Enter ?? for more actions  >>>
+ NEXT SCREEN   - PREVIOUS SCREEN  Q QUIT
Select Action: +//
```

Figure 9-10: Example Output Browser screen for the treatment prompt protocol, Page 1

- Type **Q** (Quit) to exit the OUTPUT BROWSER screen and return to the “Select Health Summary Menu Option” prompt.
- Type a plus sign (+) to display the next screen. This option is not available for the last screen.
- Type a minus sign (–) to display the previous screen. This option is not available for the first screen.

Appendix A: HMR Definitions

Below are the definitions for the HMRs.

> **Note**: For all reminders, the date the item was first due will display.
>
> **Note**: Health Maintenance Reminders with logic involving Problem List entries do not include problems with a Deleted status.

A.1 Adult MMR 1-Dose Version

Description Field Text

Default Status: Off

Denominator: Patients with no documented MMR since age 1 year:

- Born in 1957 or later who are at least 18; *or*
- Females who were born in 1957 or earlier *and* are currently less than age 50 years

> **Note**: No longer applicable

Definition (Frequency): One dose only after age 12 months

Logic Detail

MMR

- Immunizations/CVX Codes or Refusal: V Immunization 3; 94
- IZ Diagnosis (ICD Codes): V POV V06.4
- Procedures (ICD Codes): V Procedure 99.48
- Procedures (CPT Codes): V CPT 90707; 90710

Site Configurable? Yes: Sex, age range and frequencies

Tooltip Text

An MMR Immunization (one dose) is due after age 1; this adult (18+) patient born in 1957 or later has no documented MMR. Refer to the Glossary for detailed definitions.

A.2 Adult MMR 2-Dose Version

Description Field Text

Default Status: Off

Denominator: Patients with no documented MMR since age 1 year:

- Born in 1957 or later who are at least 18; *or*
- Females who were born in 1957 or earlier *and* are currently less than age 50 years

Note: No longer applicable

Definition (Frequency): Two doses total: First dose given after age 12 months, and second dose given at least one month after the first.

Logic Detail

MMR

- Immunizations/CVX Codes or Refusal: V Immunization 3; 94
- IZ Diagnosis (ICD Codes): V POV V06.4
- Procedures (ICD Codes): V Procedure 99.48
- Procedures (CPT Codes): V CPT 90707; 90710

Site Configurable? Yes: Sex, age range and frequencies

Tooltip Text

An MMR Immunization (two dose series) is due after age one; this adult (18+) patient born in 1957 or later has no documented two-dose MMR series.

A.3 Alcohol Use Screening

Description Field Text

Default Status: On

Denominator: All patients starting at age 13 years with no documented Alcohol Use Screening.

Definition (Frequency): Annually

Logic Detail

Alcohol Use Screening Definition

- V Exam 35 or Behavioral Health Module Alcohol Screening
- Measurements: V Measurement (PCC and BH) AUDC, AUDT, CRFT
- Health Factor with Alcohol/Drug Category (CAGE)
- ICD Codes: V POV V79.1
- Behavioral Health Module Diagnosis (POV) 29.1
- Patient Education Topics: V PATIENT ED or Behavioral Health Module AOD-SCR or CD-SCR

Note: Alcohol diagnoses (ICD Codes) do *not* meet this reminder.

Site Configurable? Yes: Sex, age range and frequencies

Tooltip Text

Alcohol Use Screening is due annually for all patients starting at age 13 years. Refer to the Glossary for detailed definitions.

A.4 Assessment of Function Screen

Description Field Text

Default Status: Off

Denominator: All patients starting at age 55 years

Definition (Frequency): Annually

Logic Detail

Any non-null values in V Elder Care for:

- At least one of the following ADL fields: toileting; bathing; dressing; transfers; feeding or continence and
- At least one of the following IADL fields: finances; cooking; shopping; housework/chores; medications or transportation.

Site Configurable? Yes: Sex, age range and frequencies

Tooltip Text

A functional screening is due annually for all patients starting at age 55 years.

A.5 Blood Pressure

Description Field Text

Default Status: On

Denominator: All patients starting at age three years without a history of Hypertension on the Problem List

Definition (Frequency)

- Every two years for patients starting at age three years through 20 years.
- Annually for patients age 21 years and older *and* last diastolic BP value from 85 through 89.
- At next visit for patients age 21 years and older *and* last diastolic BP was greater than 139 and/or diastolic BP was greater than 89

Logic Detail

Blood Pressure: V Measurements

Hypertension

- Diagnosis (ICD Codes): Problem List 401.0-405.99 [SURVEILLANCE HYPERTENSION taxonomy]

Site Configurable? Yes: Sex, age range and frequencies

Tooltip Text

A BP is due for all patients without hypertension (1) every two years for ages 3 through 20; (2) annually starting at age 21 if the last diastolic BP is between 85 and 89; or (3) at next visit starting at age 21, if the last systolic BP was greater than 139 and/or diastolic BP was greater than 89.

A.6 Breast Exam

Description Field Text

Default Status: Off

Denominator: All female patients starting at age 20 years

Definition (Frequency): Annually

Logic Detail

Breast Exam

- Exam Codes: V Exam 06 Breast Exam
- Diagnosis (ICD Codes): V POV V76.10, V76.12, V76.19
- Procedures (ICD Codes): V Procedure 89.36
- Procedures (CPT Codes): V CPT G0101

Site Configurable? Yes: Sex, age range and frequencies

Tooltip Text

A breast exam is due annually for all female patients beginning at age 20.

A.7 Chlamydia Screening

Description Field Text

Category: General

Status: Inactive (off)

Description: Female patients ages 16–25 with no documented Chlamydia diagnosis screened at least once for Chlamydia.

Refusals do not count toward screening.

Logic Detail

Chlamydia Trachomatis Screening

- Procedures (CPT Codes): V CPT 86631, 86632, 87110, 87270, 87320, 87490-87492, 87810 [BGP CHLAMYDIA CPTS]
- Procedures (ICD Codes): POV V738.88, V73.98
- LOINC Codes: V Lab as predefined in [BGP CHLAMYDIA LOINC CODES]
- Site Defined Lab Tests: V Lab site-defined tests in [BGP CHLAMYDIA TESTS TAX]

Chlamydia Diagnosis:

Diagnosis (ICD Codes): POV or Problem List 077.98, 078.88, 079.88, 079.98, 099.41, 099.50-59 [BKM CHLAMYDIA DXS]

Site Configurable: Ages and frequencies.

A.8 Cholesterol

Description Field Text

Default Status: On

Denominator: All male patients starting at age 35 years through age 64 years. All female patients starting at age 45 years through age 64 years.

Definition (Frequency): Every 5 years

Logic Detail

Cholesterol Definition

- Site defined Lab Tests: V Lab site defined tests in DM AUDIT CHOLESTEROL TAX
- LOINC codes: V Lab as predefined in BGP TOTAL CHOLESTEROL LOINC taxonomy
- Procedures (CPT Codes): V CPT 82465

Site Configurable? Yes: Sex, age range and frequencies

Tooltip Text

Cholesterol screening is due every five years for males aged 35–64 years and females aged 45–64 years.

A.9 Colorectal Cancer Screen–FOBT

Description Field Text

Default Status: On

Denominator: All patients starting at age 50–75 without a documented history of colorectal cancer on the problem list.

Definition (Frequency): Annually

Logic Detail

Colorectal Cancer Diagnosis

ICD Codes: Problem List only - 153.*, 154.0, 154.1, 197.5, V10.05 [BGP COLORECTAL CANCER DXS taxonomy]

Fecal Occult Blood Test (FOBT)

- Site defined Lab Tests: V Lab site defined tests in BGP GPRA FOB TESTS taxonomy
- LOINC Codes: V Lab as predefined in BGP FOBT LOINC CODES taxonomy
- Procedures (CPTS): V CPT 82270; 82274; 89205 (old code); G0107 (old code); G0328; G0394; [BGP FOBT CPTS taxonomy]

Site Configurable? Yes: Sex, age range and frequencies

Tooltip Text

A Fecal Occult Blood Test (FOBT) is due annually for all patients starting at age 50 years. Exceptions apply; see the Glossary for detailed definitions.

A.10 Colorectal Cancer Screen–Scope/X-ray

Description Field Text

Default Status: Off

Denominator: All patients starting at age 50–75 years without a documented history of colorectal cancer on the problem list.

Definition (Frequency): Variable

- Flexible Sigmoidoscopy every 5 years
- Barium Enema every 10 years
- Colonoscopy every 10 years

Logic Detail

Colorectal Cancer Diagnosis

- ICD Codes: Problem List only - 153.*, 154.0, 154.1, 197.5, V10.05 [BGP COLORECTAL CANCER DXS taxonomy]

Flexible Sigmoidoscopy

- ICD Codes: V Procedure 45.24, 45.42
- CPT Codes: V CPT 45330-45345, G0104 [BGP SIG CPTS taxonomy]

Colonoscopy

- Procedures (ICD Codes): V Procedure 45.43, 45.22, 45.23, 45.25 (BGP COLO PROCS taxonomy)
- Procedures (CPT Codes): V CPT: 44388-44394; 44397; 45355; 45378-45387; 45391; 45392; 45325 (old); G0105; G0121 [BGP COLO CPTS taxonomy]

Barium Enema

- Procedures (CPT Codes): V Radiology or V CPT: 74280; G0106; G0120 [BGP BE CPTS taxonomy]
- Procedures (ICD Codes): V Procedure 87.64

Site Configurable? Yes: Sex, age range and frequencies

Tooltip Text

A colorectal cancer screen (scope/X-ray) is due every five to ten years (depending on type of screen) for all patients starting at age 50 years. Exceptions apply.

A.11 Dental

Description Field Text

Default Status: Off

Denominator: All patients, all ages

Definition (Frequency): Annually

Logic Detail

Dental Exam

- V Dental ADA code 0000 or 0190
- V Exam or Refusal: 30 Dental Exam
- CHS visit with any ADA code

Site Configurable? Yes: Sex, age range and frequencies

Tooltip Text

A dental exam is due annually for all patients.

A.12 Depression Screen

Description Field Text

Default Status: On

Denominator: All patients, starting at age 18 years, without a documented mood disorder diagnosis in past year.

Definition (Frequency): Annually

Logic Detail

Depression Screening

- Exam: V Exam, or Refusal 36 Depression Screening, or Behavioral Health Module Depression Screening
- ICD Codes: V POV V79.0

- Patient Education Topics: V PATIENT ED or Behavioral Health Module DEP-SCR
- Measurements: V Measurement PHQ2, PHQ9, PHQT
- Behavioral Health Module Diagnosis (POV) 14.1

Mood Disorders

- ICD Codes: V POV or BH diagnosis 291.89; 292.84; 293.83; 296*; 300.4; 301.13; 311 [BGP MOOD DISORDERS taxonomy]
- BH Problem Codes: 14 or 15

Site Configurable? No

Tooltip Text

Depression screening is due annually for all patients starting at age 18 years.

A.13 Diabetes Screening

Description Field Text

Default Status: Off

Denominator: All patients starting at age 18 years without a documented diagnosis of diabetes on the problem list.

Definition (Frequency): Every three years

Logic Detail

Diabetes

- Diagnosis (ICD Codes): Problem List 250.00-250.93 [DM SURVEILLANCE DIABETES taxonomy]

Blood Glucose Laboratory Test

- Site defined Lab Tests: V Lab site defined tests in DM AUDIT GLUCOSE TESTS TAX
- LOINC Codes: V Lab as predefined in APCH SCREENING GLUCOSE LOINC taxonomy

Site Configurable? Yes: Sex, age range and frequencies

Tooltip Text

Diabetes screening (blood glucose test) is due every three years for all patients starting at age 18 years who do *not* have a problem list diagnosis of diabetes.

A.14 Domestic Violence/IPV Screening

Description Field Text

Default Status: On

Denominator: Female patients starting at age 15.

Definition (Frequency): Annually

Logic Detail

Domestic Violence/IPV Screening

- Exam Codes: V Exam 34 or Behavioral Health Module IPV/DV Exam

Site Configurable? Yes: Sex, age range and frequencies

Tooltip Text

Domestic Violence/Intimate Partner Violence Screening (DV/IPV) is due annually for females starting at age 15 years.

A.15 EPSDT SCREENING

Description Field Text

Default Status: Off

Denominator: All patients starting on the date of birth through 20 years

Definition (Frequency): Total of five times at scheduled intervals:

- Birth through 12 months
- 1 through 4 years
- 5 through 11 years
- 12 through 17 years
- 18 through 20 years

Logic Detail

EPSDT Screening Definition

Procedures (CPT Codes): V CPT:

- Age less than 1 year: New Patient 99381; Established Patient 99391
- Age 1 through 4 years: New Patient 99382; Established Patient 99392
- Age 5 through 11 years: New Patient 99383; Established Patient 99393

- Age 12 through 17 years: New Patient 99384; Established Patient 99394
- Age 18 through 20 years: New Patient 99385; Established Patient 99395

Site Configurable? Yes: Sex, age range and frequencies

Tooltip Text

An Early Periodic Screening and Diagnosis and Treatment (EPSDT) screening is due at regular intervals for all patients starting at birth through age 20 years.

A.16 Fall Risk Assessment

Description Field Text

Default Status: On

Denominator: All patients starting at age 65 years.

Definition (Frequency): Annually

Logic Detail

Fall Risk Assessment

- Exam Codes: V Exam or Refusal 37 Fall Risk
- History of Falling Diagnosis (ICD Codes): V POV V15.88
- Abnormal Gait/Balance/Mobility Diagnosis (ICD Codes): 781.2-781.3; 719.7; 719.70 (old code); 719.75; 719.77 (old codes); 438.84; 333.99; 443.9 [BGP ABNORMAL GAIT OR MOBILITY taxonomy]
- Fall-related Injury Diagnosis (Cause Codes #1-3) E880.*; E881.*; E883.*; E884.* E885.*; E886.* E888.* [BGP FALL RELATED E-CODES taxonomy]

Site Configurable? Yes: Sex, age range and frequencies

Tooltip Text

A fall risk assessment is due annually for all patients starting at age 65 years.

A.17 HCT/HGB

Description Field Text

Default Status: On

Denominator

- All patients at age 12 months with no Hct/Hgb laboratory test documented during ages 9 through 12 months
- All patients at age four years with no Hct/Hgb laboratory test documented during ages three through four years

Definition (Frequency): Two times: Once at age 12 months and again at age four years. This reminder will continue to appear for patients through age 10 years, until the test is documented.

Logic Detail

Hemoglobin/Hematocrit (HCT/HGB) test

- Site defined Lab Tests: V Lab site defined tests in APCH HCT/HGB TESTS taxonomy
- LOINC Codes: V Lab as predefined in APCH HCT/HGB LOINC CODES taxonomy

Site Configurable? Yes: Sex, age range and frequencies

Tooltip Text

A hemoglobin/hematocrit is due for all patients at age 12 months and then again at age four years.

A.18 Head Circumference

Description Field Text

Default Status: On

Denominator: All patients starting at date of birth through age three years.

Definition (Frequency): Seven times total in regular intervals: once each at birth; two months; four months; six months; 12 months; 18 months; and 24 months of age. The reminder will appear for patients through age three years, until the test is documented.

Logic Detail

Head Circumference: V Measurement HC

Site Configurable? Yes: Sex, age range and frequencies

Tooltip Text

A head circumference measurement is due at regular intervals for all patients starting at birth through 24 months.

A.19 Hearing Test

Description Field Text

Default Status: On

Denominator: All patients at age 4 with no documented hearing test from ages three to four years; does not count any hearing test before age three.

Definition (Frequency): One time. This reminder will continue to appear for patients through age seven years, until the test is documented.

Logic Detail

Hearing Test

- Exam Codes: V Exam 17-HEARING (Inactive), 23-AUDIOMETRIC (Inactive)
- 24-AUDIOMETRIC THRESHOLD (Inactive)
- Screening Diagnosis (ICD Codes): V POV V72.1*
- Measurements: V Measurement HEARING or AUDIOMETRY
- Procedures (CPT Codes): [APCH HEARING SCREEN CPTS]
- Diagnoses: [APCH HEARING LOSS DXS]

Site Configurable? Yes: Sex, age range and frequencies

Tooltip Text

A hearing test is due for all patients at age four years.

A.20 Height

Description Field Text

Default Status: On

Denominator: All patients starting on the date of birth (DOB)

Definition (Frequency)

- Once each at birth; two months; four months; six months; 12 months; 18 months;
  and 24 months
- Annually starting at age three years through 17 years
- Once at or after age 18 years through 64 years
- Annually at ages older than 64 years

Logic Detail

Height: V Measurements Height

Site Configurable? Yes: Sex, age range and frequencies

Tooltip Text

A height is due routinely for all patients, depending on age: Annually for ages 3–17 and older than 64; once for ages 18–64; frequently for children less than 3 years.

A.21 HIV Screening

Description Field Text

Category: General

Status: Active (on)

Description: All patients ages 13–64 with no recorded HIV diagnosis ever should be screened at least once, not to include Refusals. This reminder will appear until an HIV screening is performed.

Site Configurable: Sex, age and frequencies.

A.22 Influenza

Description Field Text

Default Status: On

Denominator: Patients with no documented flu immunization this year

- Ages 65 years and older, *or*
- With a high risk diagnosis on the problem list, including pulmonary tuberculosis, pneumococcal septicemia, Human Immunodeficiency Virus (HIV)/acquired immunodeficiency syndrome (AIDS), cardiovascular syphilis, candidal endocarditis, myocarditis due to toxoplasmosis, malignant neoplasms, other immunity disorders, diseases of the blood, alcohol dependence, drug abuse, various rheumatic fevers, chronic rheumatic heart disease, hypertensive disease, heart disease, chronic obstructive pulmonary disease (COPD), asthma, lung and other respiratory diseases, liver diseases, nephritis and other urinary system diseases, arthropathies, inflammatory polyarthropathies, dorsopathies, injury to spleen, transplanted organ complication, and chemotherapy.

Definition (Frequency): Annually between September 1st and April 1st

Logic Detail

Flu Shot

- Immunization/CVX Codes: V Immunization or Refusal 15, 16, 88, 111
- Diagnosis (ICD Codes): V POV V06.6; V04.8 (old code); V04.81 [BGP FLU IZ DXS taxonomy]
- Procedures (ICD Codes): V PROCEDURE 99.52 [BGP FLU IZ PROCEDURES taxonomy]
- Procedures (CPT Codes): V CPT 90655-90662; 90724 (old code); G0008; G8108 [BGP CPT FLU taxonomy]

High-Risk Diagnosis

- Diagnosis (ICD Codes): Problem List 011.00-011.96; 038.2; 042.0-044.9; 093.0-093.9; 112.81; 130.3; 140.0-208.91; 235.0-239.9; 240.0-279.9; 280.0-289.9; 303.00-303.93; 305.00-305.03; 331.7; 391.0-391.9; 393.-398.99; 401.0-405.91; 410.0-414.9; 415.0-417.9; 420.0-438.99; 440.1; 490.-496.; 500.-508.99; 510.0-519.9; 570.-572.8; 580.0-589.9; 590.00-599.9; 710.0-710.9; 714.0-714.9; 720.0-721.41; 759.0; 785.2-785.3; 865.00-865.19; 996.80-996.89; V08.; V42.0-V42.9; V58.1 [SURVEILLANCE PNEUMOCOCCAL RISK taxonomy]

Site Configurable? Yes: Sex, age range and frequencies

Tooltip Text

An influenza immunization is due annually for all patients ages 65 and older *or* those who are considered at risk.

A.23 LDL Screening for IHD Patients

Description Field Text

Default Status: Off

Denominator: All patients ages 18 or older with Ischemic Heart Disease (IHD) with no documented LDL within past year.

Definition (Frequency): One time.

This reminder will continue to appear until the screening is documented.

Logic Detail

IHD Defined as any Problem List Entry or a POV within the Past Year: 410.0-412.*; 414.0-414.9; 428*, or 429.2 (BGP IHD DXS taxonomy).

LDL screening test is defined by the site-populated taxonomy DM AUDIT LDL CHOLESTEROL TAX.

If LDL test was documented as refused within the last 12 months, the prompt will display on the following line, “Pt refused LDL test on [***] date” and any accompanying provider note.

Tooltip Text

- May be due now; *or*
- Pt refused LDL test on [***date]

A.24 Mammogram

Description Field Text

Default Status: On

Denominator: All females starting at age 50 years through age 69 years.

Definition (Frequency): Annually

Logic Detail

The due date is derived by comparing any PCC data to any Women’s Health (WH) application. If a BREAST TX Need is documented in WH, the date is compared to the most recent PCC procedure (V Rad, V CPT, V POV or V Procedure), if any. If the WH due date is greater than the PCC date, use the WH date. If no WH procedure or procedure date exists, the due date is calculated from the most recent PCC procedure, if any. Otherwise the procedure is due now.

Mammogram

- Diagnosis (ICD Codes): V76.11, V76.12 [BGP MAMMOGRAM ICDS taxonomy]
- Procedures (CPT Codes): V Radiology or V CPT: 76083 (old code) 76090-76092,(old codes) G0206, G0204, G0202 [BGP CPT MAMMOGRAM taxonomy]
- Procedures (ICD Codes): V Procedures 87.36, 87.37 [BGP MAMMOGRAM PROCEDURES taxonomy]
- Women’s Health Procedure (BW): Screening Mammogram, Mammogram Dx Bilat, Mammogram Dx Unilat

Site Configurable? Yes: Age range and frequency (not sex)

Tooltip Text

A mammogram is due annually for females ages 50 through 69. Exceptions apply.

A.25 Newborn Hearing Screen

Description Field Text

Default Status: On

Denominator: All patients until age one with no documented hearing tests in both ears.

Definition (Frequency): One time. This reminder will continue to appear for patients through age 1 year until the tests are documented for *both* ears or age one is reached.

Logic Detail

Newborn Hearing Screening–Exam: V Exam 38 Newborn Hearing Screen (Right) AND 39 Newborn Hearing Screen (Left); must have both exam codes documented.

- Diagnosis (ICD) Codes: V POV or Problem List: 389.00-389.9; 744.00-744.02; 794.15 (APCH Hearing Loss DXS)
- Procedures (CPTs): V CPT 99431; 99435 (APCH Newbrn Hear Scrn CPTS) or 92551; 92552; 92553; 92587; 92555; 92556; 92557; 92579; 92582; 92583; 92585; 92586; 92590-92594; 92620-92621; 92630 (APCH Hearing Screen CPTS)
- Procedures (ICD): V POV V72.1-V72.19

Site Configurable? No

A.26 Osteoporosis Screening

Description Field Text

Default Status: Off

Denominator: All female patients ages 65 years and older without a documented history of osteoporosis.

Definition (Frequency): Once every two years.

This reminder will continue to appear until the screening is documented.

Site Configurable? Yes: Age and frequency

Tooltip Text

Osteoporosis screening should be done every two years for all female patients ages 65 years and older without a documented history of osteoporosis.

A.27 Pap Smear

Description Field Text

Default Status: On

Denominator: All females without a history of a hysterectomy starting at age 18 years.

Definition (Frequency): Every three years

Logic Detail

Last pap smear from PCC is retrieved. The WH application is then checked. If there is a CX TX need documented, compare that to PCC. If the date is greater than the date displayed in PCC, use the date from the WH package as the "Last Done" date. If no date or unknown in WH, the due date is calculated from the most recent PCC procedure, if any. Otherwise, the procedure is due now.

Pap Smear

- Site defined Lab Tests: V Lab site defined tests in [BGP PAP SMEAR TAX taxonomy]
- LOINC Codes: V Lab as predefined in BGP PAP LOINC CODES taxonomy
- Diagnosis (ICD Codes): V POV V67.01; V76.2; V72.32; V72.3; V76.47; 795.06 [BGP PAP SMEAR DXS taxonomy]
- Procedures (ICD Codes): V Procedure 91.46 [BGP PAP PROCEDURES taxonomy]
- Procedures (CPT Codes): V CPT 88141-88167; 88174-88175; G0101; G0123; G0124; G0141; G0143;-G0145; G0147; G0148; P3000; P3001; Q0091 [BGP CPT PAP taxonomy]
- Women's Health Procedures: PAP SMEAR

Hysterectomy

- Procedures (ICD Codes): V Procedure 68.4-68.8 [BGP HYSTERECTOMY PROCEDURE taxonomy]
- Procedures (CPT Codes): V CPT 51925; 56308 (old code); 58150; 58152; 58200-58294; 58458; 58550-58554; 58951; 58953-58954; 58956; 59135 [BGP HYSTERECTOMY CPTS taxonomy]

- Diagnosis (ICD Codes): V POV 618.5

Site Configurable? Yes: Age range and frequency (not sex)

Tooltip Text

A pap smear is due every three years for females without a history of hysterectomy starting at age 18 years. For patients with a history of hysterectomy, a pap smear may be indicated based on clinical assessment.

A.28 PPD–Tuberculosis

Description Field Text

Default Status: On

Denominator

- All patients without a documented history or current diagnosis of tuberculosis at age four years with no documented PPD between ages three and four years.
- All patients without a documented history or current diagnosis of tuberculosis at age 11 years with no documented PPD between ages 9 and 11 years.

This reminder will continue to appear for patients through age 18, until the test is documented.

Definition (Frequency): Two times: Once at age four years and once at age 11 years

Logic Detail

PPD: V SKIN TEST: PPD

Tuberculosis

Diagnosis (ICD Codes): Problem List 010.00-018.96; 137.0-137.4; 795.5; V12.01 [SURVEILLANCE TUBERCULOSIS taxonomy]

Health Factors: V Health Factor any TB Treatment category

Site Configurable? Yes: Sex, age range and frequencies

Tooltip Text

A tuberculosis test (PPD) is due for all patients at age four years and then again at age 11 years. Exceptions apply.

A.29 Pelvic Exam

Description Field Text

Default Status: Off

Denominator: All female patients starting at age 18 years

Definition (Frequency): Annually

Logic Detail

Pelvic Exam

- Exam Codes: V Exam 15 Pelvic Exam
- Screening Diagnosis (ICD Codes): V POV V72.31, V72.32
- Procedures (CPT Codes): V CPT G0101

Site Configurable? Yes: Sex, age range and frequencies

Tooltip Text

A pelvic exam is due annually for all female patients starting at age 18 years. Refer to Section 20.0 for detailed definitions.

A.30 Physical Exam

Description Field Text

Default Status: Off

Denominator: All patients starting at age 18 years

Definition (Frequency): Annually

Logic Detail

Physical Exam

- Exam Codes: V Exam Physical Exam 01 (Inactive)
- Diagnosis (ICD Codes): V POV V70.0-V70.9 [SURVEILLANCE PHYSICAL EXAM taxonomy]
- Procedures (CPT Codes): V CPT 99391-99397; G0344 [APCH GENERAL EXAM CPTS taxonomy]

Site Configurable? Yes: Sex, age range and frequencies

Tooltip Text

A physical exam is due annually for all patients starting at age 18 years.

A.31 Pneumovax

Description Field Text

Default Status: On

Denominator

- All patients ages 65 years and older with no documented pneumovax or only one documented five or more years ago; *or*
- All patients ages 5 years through 10 years *and* a high risk diagnosis on the problem list with no documented pneumovax ever or only one documented three or more years ago; *or*
- All patients' ages 11 years through 64 years *and* a high risk diagnosis on the problem list with no documented pneumovax ever or only 1 documented 5 or more years ago.

Definition (Frequency): At least two, but not more than five years apart (three years for ages 5–10).

Logic Detail

Pneumococcal Immunization

- Immunization/CVX Codes: V Immunization or Refusal 33, 100, 109
- Diagnosis (ICD Codes): V POV V06.6; V03.82 [BGP PNEUMO IZ DXS taxonomy]
- Procedures (ICD Codes): V PROCEDURE 99.52
- Procedures (CPT Codes): V CPT 90669; 90732 [BGP PNEUMO IZ CPTS taxonomy]
- High risk diagnosis, including pulmonary tuberculosis, pneumococcal septicemia, HIV/AIDS, cardiovascular syphilis, candidal endocarditis, myocarditis due to toxoplasmosis, malignant neoplasms, other immunity disorders, diseases of the blood, alcohol dependence, drug abuse, various rheumatic fevers, chronic rheumatic heart disease, hypertensive disease, heart disease, COPD, asthma, lung and other respiratory diseases, liver diseases, nephritis and other urinary system diseases, arthropathies, inflammatory polyarthropathies, dorsopathies, injury to spleen, transplanted organ complication, chemotherapy

- Diagnosis (ICD Codes): Problem List 011.00-011.96; 038.2; 042.0-044.9; 093.0-093.9; 112.81; 130.3; 140.0-208.91; 235.0-239.9; 240.0-279.9; 280.0-289.9; 303.00-303.93; 305.00-305.03; 331.7; 391.0-391.9; 393.-398.99; 401.0-405.91; 410.0-414.9; 415.0-417.9; 420.0-438.99; 440.1; 490.-496.; 500.-508.99; 510.0-519.9; 570.-572.8; 580.0-589.9; 590.00-599.9; 710.0-710.9; 714.0-714.9; 720.0-721.41; 759.0; 785.2-785.3; 865.00-865.19; 996.80-996.89; V08.; V42.0-V42.9; V58.1 [SURVEILLANCE PNEUMOCOCCAL RISK taxonomy]

Site Configurable? Yes: Sex, age range and frequencies

Tooltip Text

Two pneumovax are due at specific intervals for all patients ages 65 and older *or* those who are considered at risk.

A.32 Rectal Exam

Description Field Text

Default Status: Off

Denominator: All patients starting at age 40 years

Definition (Frequency): Annually

Logic Detail

Rectal Exam

- V Exam: Rectal Exam 14 (currently Inactive)
- V POV: V76.41; V76.44
- V Procedure: 89.34
- V CPT: G0102; S0601; S0605

Site Configurable? Yes: Sex, age range and frequencies

Tooltip Text

A rectal exam is due annually for all patients starting at age 40 years.

A.33 TD Adult

Description Field Text

Default Status: On

Denominator: All patients starting at age 12 years with no history of allergy to Tetanus Diphtheria Vaccine

Definition (Frequency): Every 10 years

Logic Detail

Tetanus Diphtheria (TD)

- Immunizations/CVX Codes: V Immunization 1, 9, 20, 22, 28, 35, 50, 106, 107, 110, 112, 113, 115
- Procedures (CPT Codes): V CPT 90700-90703; 90718; 90720-90723 [APCH TD CPTS taxonomy]

Site Configurable? Yes: Sex, age range and frequencies

Tooltip Text

A Tetanus-Diphtheria (TD) vaccine is due every ten years for all patients with no documented history of TD allergy starting at age 12 years.

A.34 Tobacco Use Screening

Description Field Text

Default Status: On

Denominator: All patients starting at age 13 years

Definition (Frequency): Annually

LOGIC DETAIL

Tobacco Screening

- Health Factors: V Health Factor in any category TOBACCO (SMOKING), TOBACCO (SMOKELESS – CHEWING/DIP), TOBACCO (EXPOSURE)
- Diagnoses (ICD Codes): V POV or Problem List 305.1; 305.1* (old codes); 649.00-649.04; V15.82 [BGP GPRA SMOKING DXS taxonomy]
- V Dental: ADA 1320
- Procedures (CPT Codes): V CPT 1034F; 1035F; 1036F [BGP TOBACCO USE CPTS taxonomy] or 99406; 99407; G0375 (old code); G0376 (old code) [BGP TOBACCO SCREEN CPTS taxonomy]

Site Configurable? Yes: Sex, age range and frequencies

Tooltip Text

Tobacco use screening is due annually for all patients starting at age 13.

A.35 Tonometry

Description Field Text

Default Status: Off

Denominator: All patients starting at age 40 years

Definition (Frequency): Every three years for patients ages 40 years through 59 years; annually starting at age 60 years.

Logic Detail

Tonometry Definition

- Exam Codes: V exam 23 (Inactive)
- Measurements: V Measurement TON
- Procedures (ICD Codes): V Procedures 89.11; 95.26
- Procedures (CPT Codes): V CPT S0620; S0621; 92100; 92120; 92499

Site Configurable? Yes: Sex, age range and frequencies

Tooltip Text

A tonometry test is due every three years for all patients starting at age 40 years through age 59 years, and then annually starting at age 60 years.

A.36 Urinalysis

Description Field Text

Default Status: Off

Denominator: All patients at age five years with no documented test from ages three through five years.

Definition (Frequency): Once only

This reminder will continue to appear for patients through age 14 years, until the test is documented.

Logic Detail

Urinalysis

- **Site-Defined Lab Tests**: V Lab site defined tests in DM AUDIT URINALYSIS TAX taxonomy

- **LOINC Codes**: V Lab as predefined in DM AUDIT URINALYSIS LOINC taxonomy

Site Configurable? Yes: Sex, age range and frequencies

Tooltip Text

A urinalysis is due for all patients at age 5 years.

A.37 Visual Acuity Exam

Description Field Text

Default Status: On

Denominator: All patients starting at age 65 years

Definition (Frequency): Every two years

Logic Detail

Visual Acuity Exam

- Exam Codes: V Exam 19 Vision Exam (Inactive)
- Measurements: V Measurement VU VISION UNCORRECTED or VC VISION CORRECTED
- Procedures (ICD Codes): V Procedures 95.09; 95.05
- Procedures (CPT Codes): V CPT 99172; 99173
- Screening Diagnosis: V POV V72.0

Site Configurable? Yes: Sex, age range and frequencies

Tooltip Text

A visual acuity exam is due every two years for all patients starting at age 65 years.

A.38 Weight

Description Field Text

Default Status: On

Denominator: All patients starting on the date of birth

Definition (Frequency)

- Every visit for ages birth through five months

- Every two months for ages six through 11 months
- Every three months for ages 12 months through five years
- Every six months for ages six through 15 years
- Annually starting at age 16 years

Logic Detail

Weight: V-Measurements

Site Configurability: Yes: sex, age range and frequencies

Tooltip Text

A weight is due routinely for all patients, depending on age; annually for all patients ages 16 years and older; biannually for ages 6–15 years; more often for ages younger than six.

Appendix B: Best Practice Prompt Definitions

Below are the definitions for the best practice prompts.

B.1 Anticoagulation: Anticoagulation Therapy End Date

Description Field Text

Default Status: On

Description: The Anticoagulation Therapy End Date is a calculation based on the established Duration of Anticoagulation Therapy and Anticoagulation Therapy Start date. When today's date is within 45 days of this calculated date, the user will be prompted to consider reassessment of the need for continued therapy. Extending the Duration of Anticoagulation Therapy will result in a recalculation of the Anticoagulation Therapy End Date.

This best practice prompt will only be displayed if the patient is onWarfarin and meets the above criteria for the prompt to display. The definition of "on Warfarin" is that the patient had a Warfarin medication dispensed in the past 120 days and the last one dispensed was not discontinued.

Best Practice Prompt Text

Anticoagulation Therapy End Date: This patient's Anticoagulation therapy is scheduled to end on [DATE]|. Consider reassessing your patient's continued need for Warfarin therapy.

B.2 Anticoagulation: Duration of Anticoagulation Therapy

Description Field Text

Default Status: On

Description: It is recommended that patients who are on anti-coagulation therapy have a Duration of Anticoagulation Therapy established for them by their provider. The options include: three months; six months; 12 months or indefinitely. This can be reassessed periodically based on the patient's need for continuing therapy. Reestablishing the Duration of Anticoagulation Therapy initiates a re-calculation of the Anticoagulation Therapy End Date.

This best practice prompt will only be displayed if the patient is on Warfarin and meets the above criteria for the prompt to display. The definition of "on Warfarin" is that the patient had a Warfarin medication dispensed in the past 120 days and the last one dispensed was not discontinued.

Best Practice Prompt Text

No Duration of Anticoagulation Therapy: This patient is on Warfarin and a Duration of Anticoagulation Therapy is not documented.

B.3 Anticoagulation: INR Goal

Description Field Text

Default Status: On

Description: It is recommended that patients who are on anti-coagulation therapy have an INR Goal Range established for them by their provider. The options for these ranges include: 2.0–3.0 *or* 2.5–3.5 *or* Other. If Other is selected, providers will enter both minimum and maximum values for the range.

This best practice prompt will only be displayed if the patient is on Warfarin and meets the above criteria for the prompt to display. The definition of “on Warfarin" is that the patient had a Warfarin medication dispensed in the past 120 days and the last one dispensed was not discontinued.

Best Practice Prompt Text

No INR Goal: This patient is on Warfarin and has never had an INR Goal range documented.

B.4 Anticoagulation: Safety Measure: CBC

Best Practice Prompt Text

Default Status: On

Description: Clinical Guidelines recommend that patients on Anticoagulation therapy have a CBC annually.

Definition (Frequency): Annually

Logic Detail

- A CBC is defined as CPT Codes: 85025-85027 [BGP CBC CPT]
- LOINC Codes contained in [BGP CBC LOINC]; [BGP CBC TESTS].

This best practice prompt will only be displayed if the patient is on Warfarin and meets the above criteria for the prompt to display. The definition of "on Warfarin" is that the patient had a Warfarin medication dispensed in the past 120 days and the last one dispensed was not discontinued.

Best Practice Prompt Text

No CBC: A Complete Blood Count (CBC) is recommended annually for patients on Warfarin. The last CBC was reported on |ACCBCDT|.

B.5 Anticoagulation: Safety Measure: FOBT

Description Field Text

Default Status: On

Description: It is recommended that patients on anti-coagulation therapy have an Fecal Occult Blood Test (FOBT) annually. Patients with no documented FOBT in the past year will be prompted to consider ordering this test.

Definition (Frequency): Annually

Logic Detail

FOBT or Fecal Immunochemical Test (FIT): CPT 82270, 82274, 89205 (old code), G0107 (old code), G0328, G0394 (old code); BGP FOBT LOINC CODES (LOINC taxonomy); or site-populated taxonomy BGP GPRA FOB TESTS

This best practice prompt will only be displayed if the patient is on Warfarin and meets the above criteria for the prompt to display. The definition of "on Warfarin" is that the patient had a Warfarin medication dispensed in the past 120 days and the last one dispensed was not discontinued.

Best Practice Prompt Text

No FOBT: A FOBT is recommended annually for patients on Warfarin. The last FOBT was reported on |ACFOBTDT|.

B.6 Anticoagulation: Safety Measure: Urinalysis

Description Field Text

Default Status: On

Description: Clinical Guidelines recommend that patients on Anticoagulation therapy have a urinalysis annually.

Logic Detail

A urinalysis is defined as LOINC Codes contained in [DM AUDIT URINALYSIS LOINC], [DM AUDIT URINALYSIS TAX] or [BJPC URINALYSIS CPT].

This best practice prompt will only be displayed if the patient is on Warfarin and meets the above criteria for the prompt to display. The definition of "on Warfarin" is that the patient had a Warfarin medication dispensed in the past 120 days and the last one dispensed was not discontinued.

Best Practice Prompt Text

No Urinalysis: A Urinalysis (UA) is recommended annually for patients on Warfarin. This patient's last UA was reported on |ACURINDT|.

B.7 Asthma: Action Plan

Description Field Text

Default Status: On

Denominator: Patients with asthma who do not have a documented Action (Management) Plan in the past year. Asthma is defined as:

- Any asthma severity ever of 2, 3, or 4; *or*
- iCare active asthma tag; *or*
- At least three instances of asthma primary diagnosis in the past six months
- Last documented asthma control status "not well controlled" or "very poorly controlled;" *or*
- History of asthma exacerbation in the past year; *or*
- At least one ER or Urgent Care visit in the past year with a primary diagnosis of asthma

Definition (Frequency): Annually

Logic Detail

Asthma Diagnosis

- Diagnosis (ICD Codes) {not on same day, Primary dx only, and Service Category A (Ambulatory) or H (Hospitalization) only}: V POV 493.00-493.92 (BGP ASTHMA DXS taxonomy)
- Asthma severity:
  - Problem list classification: Category Asthma: 2-mild persistent, 3-moderate persistent, 4-severe persistent
- Active asthma tag (iCare): Status Proposed or Accepted
- Control status: V Asthma Control values "not well controlled" or "very poorly controlled"

Asthma Exacerbation

- Diagnosis (ICD Codes) Service Category A (Ambulatory) or H (Hospitalization) only:
  - V POV 493.01 EXT ASTHMA W STATUS ASTH; 493.02 EXTRINSIC ASTHMA, W ACUTE EXA; 493.11 INT ASTHMA W STATUS ASTH; 493.12 INTRINSIC ASTHMA, W ACUTE EXA; 493.21 CHR OBSTR ASTH WITH STAT ASTH; 493.22 CHR OBSTR ASTHMA W ACUTE EXA
- Emergency Room (ER) visit: Clinic code 30
- Urgent Care visit: Clinic code 80

Best Practice Prompt Text

The asthma guidelines recommend providing the patient with an AAP because they have [asthma criteria]. The AAP provides information on daily management and early recognition of and actions for handling exacerbations. It should contain a list of medications for controlling asthma and actions to take when asthma worsens. Document AAP in patient education with (ASM-SMP Self-Management Plan).

Site Configurable?: No.

Tooltip Text

This patient has no action plan documented in the past year. Clinical guidelines recommend that patients with documented asthma diagnosis should have an action plan documented annually.

B.8 Asthma: Add/Increase Inhaled Steroids

Description Field Text

Default Status: On

Denominator: Patients with asthma who do not have a prescription in the past six months for inhaled corticosteroids. Asthma is defined as:

- Any asthma severity ever of category 2, 3 or 4; *or*
- iCare active asthma tag; *or*
- At least three instances of asthma primary diagnosis in the past six months

Definition (Frequency): As needed when no current prescription.

Logic Detail

Asthma Diagnosis

- Diagnosis (ICD Codes) (not on same day, Primary dx only, and Service Category A or H only)
  - V POV 493.00-493.92 (BGP ASTHMA DXS taxonomy)
- Asthma Severity (Problem List Classification)
  - Category Asthma:
    - 2-Mild persistent, 3-Moderate persistent, 4-Severe persistent
- Active Asthma tag (iCare): Status Proposed or Accepted

Inhaled Corticosteroids

- Site-Defined Medications: V Medications in BAT ASTHMA INHALED STEROIDS taxonomy
- NDC (National Drug Codes): V Medications as predefined in BAT ASTHMA INHLD STEROIDS NDC taxonomy

Best Practice Prompt Text

If this patient has asthma, consider adding or increasing this patient's inhaled corticosteroids.

Site Configurable?: No.

Tooltip Text

This patient has no documented current prescription for inhaled steroids. Clinical guidelines recommend that patients with documented asthma diagnosis should have a current prescription for inhaled corticosteroids.

B.9 Asthma: Control Classification

Description Field Text

Denominator: Patients with asthma who do not have asthma control documented in the past year. Asthma is defined as:

- Any asthma severity ever of category 2, 3, or 4; *or*
- iCare active asthma tag; *or*
- At least three instances of asthma primary diagnosis in the past six months.

Definition (Frequency): Annually.

Logic Detail

Asthma Diagnosis

- Diagnosis (ICD Codes): Not on same day, Primary dx only, and Service Category A or H only

  - V POV 493.00-493.92 (BGP ASTHMA DXS taxonomy)
- Asthma Severity (Problem List Classification)
  - Category Asthma: 2-Mild persistent, 3-Moderate persistent, 4-Severe persistent
- Active asthma tag (iCare): Status Proposed or Accepted
- Asthma Control
  - V Asthma Control, any value

Best Practice Prompt Text

Asthma control should be assessed at each patient visit. This patient has not been assessed for asthma control in the past year. Please consider classifying the control of this patient's asthma. Classifications are (1) well controlled, (2) not well controlled, or (3) very poorly controlled.

Site Configurable?: No.

Tooltip Text

This patient has no control documented in the past year. Clinical guidelines recommend that patients with documented asthma diagnosis should have their asthma control documented at each visit.

B.10 Asthma: Flu Shot

Description Field Text

Default Status: On

Denominator: Patients with asthma who do not have an influenza immunization documented during the current flu season. Asthma is defined as:

- Any asthma severity ever of category 2, 3 or 4; *or*
- iCare active asthma tag; *or*
- At least three instances of asthma primary diagnosis in the past six months *or*
- Current prescription for inhaled corticosteroids

Definition (Frequency): Annually during the months of September through March only.

Logic Detail

A**sthma Diagnosis**

- Diagnosis (ICD Codes): Not on same day, Primary dx only, and Service Category A or H only

  - V POV 493.00-493.92 (BGP ASTHMA DXS taxonomy)
- Asthma severity (Problem List Classification):
  - Category Asthma: 2-Mild persistent, 3-Moderate persistent, 4-Severe persistent
- Active asthma tag (iCare): Status Proposed or Accepted Inhaled Corticosteroids
- Site-Defined Medications: V Medications in BAT ASTHMA INHALED STEROIDS taxonomy
- NDC (National Drug Codes): V Medications as predefined in BAT ASTHMA INHLD STEROIDS NDC taxonomy

Best Practice Prompt Text

It is recommended that all asthma patients receive a flu shot. If this patient has asthma (as documented on [most recent visit date with asthma POV]) consider giving this patient flu shot per protocol during the season.

Site Configurable?: No.

Tooltip Text

This patient has no documented flu shot during this flu season. Clinical guidelines recommend that patients with documented asthma diagnosis should have an annual influenza immunization.

B.11 Asthma: Increased Risk for Exacerbation

Description Field Text

Default Status: On

Denominator: Patients with increased risk for asthma exacerbation, defined as:

- Two or more ER, Urgent Care, or inpatient visits in the last year (not on the same day) with a documented primary diagnosis of asthma; *or*
- One prescription for oral corticosteroids on the same day as a visit with primary asthma diagnosis in the last year for patients with *only* asthma severity 1 (intermittent); *or*
- Two prescriptions for oral corticosteroids on the same day as a visit with primary asthma diagnosis in the last year for patients with *any* asthma severity 2, 3, or 4 (persistent); *or*

- At least one ER, Urgent Care, or inpatient visit in the last year with a documented primary diagnosis of asthma *and* one prescription for oral corticosteroids on the same day as a visit with primary asthma diagnosis in the last year on a date at least two weeks (14 days) before or after the ER/UC/inpatient visit.

Definition (Frequency): As needed.

Logic Detail

Asthma Diagnosis

- Diagnosis (ICD Codes): Not on same day, Primary dx only, and Service Category A or H only
  - V POV 493.00-493.92 (BGP ASTHMA DXS taxonomy)
- Asthma Severity: Problem List Classification category
  Asthma Severity, any value
- Emergency Room (ER) visit: Clinic code 30
- Urgent Care visit: Clinic Code 80
- Inpatient (hospital) visit: Visit Service Category H

Oral Corticosteroids

Site defined Medications: V Medications in BGP RA GLUCOCORTICOIDS taxonomy

VA Drug Class: V Medications as predefined in BGP RA GLUCOCORTICOIDS CLASS taxonomy

Best Practice Prompt Text

This patient may be at increased risk for future asthma exacerbations. The documented asthma severity is ([Severity] or “None Documented”). They had the following events which may have resulted from uncontrolled asthma.

- [Event Trigger1]
- [Event Trigger2]

Making sure that the patient’s asthma is well controlled will help to prevent further exacerbations.

Site Configurable?: No.

Tooltip Text

This patient may be at increased risk for future asthma exacerbations. The provider should ensure the patient’s asthma is well controlled.

B.12 Asthma: Primary Care Provider

Description Field Text

Default Status: On

Denominator: Patients with asthma who do not have a Designated Primary Care Provider (DPCP) documented. Asthma is defined as:

- Any asthma severity ever of category 2, 3 or 4; *or*
- iCare active Asthma tag; *or*
- At least three instances of asthma primary diagnosis in the past six months.

Definition (Frequency): As needed when no DPCP documented.

Logic Detail

Asthma Diagnosis

- Diagnosis (ICD Codes): Not on same day, Primary dx only, and Service Category A or H only
  - V POV 493.00-493.92 (BGP ASTHMA DXS taxonomy)

Asthma Severity (Problem List Classification)

- Category Asthma: 2-Mild persistent, 3-Moderate persistent, 4-Severe persistent
- Active Asthma tag (iCare): Status Proposed or Accepted

Designated Primary Care Provider

- Designated Specialty Provider Management (DSPM): Provider role DPCP
- Patient File: Primary Care Provider

Best Practice Prompt Text

This patient has a chronic condition. Guidelines recommend that patients with chronic conditions have a PCP. Please assign this patient to a primary care provider.

Site Configurable?: No.

Tooltip Text

This patient has no DPCP assigned. Clinical guidelines recommend that patients with chronic conditions such as asthma have a PCP.

B.13 Asthma: Severity Classification

Description Field Text

Default Status: On

Denominator: Patients with asthma who do not have a documented asthma severity. Asthma is defined as:

- iCare active asthma tag; *or*
- At least three instances of asthma primary diagnosis in the past six months.

Definition (Frequency): Once

Logic Detail

Asthma Diagnosis

- Diagnosis (ICD Codes): Not on same day, Primary dx only, and Service Category A or H only
  - V POV 493.00-493.92 (BGP ASTHMA DXS taxonomy)
- Active Asthma tag (iCare): Status Proposed or Accepted

Asthma Severity - Problem List Classification

- Category asthma severity, any value: 1-Intermittent, 2-Mild persistent, 3-Moderate persistent, 4-Severe persistent

Best Practice Prompt Text

If this patient has asthma, consider classifying the severity of this patient's asthma in the Problem List Classification field.

Site Configurable?: No.

Tooltip Text

This patient has no documented asthma severity. Clinical guidelines recommend that patients with documented asthma diagnosis should have asthma severity assessed and documented to assist with treatment planning.

B.14 CVD At Risk: Missing Risk Factors

Description Field Text

Default Status: ACTIVE (ON)

Denominator: Patients with active CVD At Risk (CVD AR) tag (iCare) who are not documented in RPMS for any or all of the following CVD risk factors:

- Tobacco Use Screen in the past year; and/or
- Total Cholesterol test in past 5 years; and/or
- HDL with result in past 5 years; and/or
- LDL with result in past 5 years; and/or
- Blood Pressure in the past year

Definition (Frequency): As needed when any risk factors are missing.

Logic Detail

CVD At Risk tag (Proposed or Accepted): If patient is not categorized with Known CVD, CVD At Highest Risk or CVD At Significant and meets the following criteria:

- Male equal to or greater than age 45; or
- Female equal to or greater than age 55

Tobacco Use Screen

- Health Factors: Most recent V Health Factor TBD BGP TOBACCO USER HLTH FACTORS taxonomy
- Diagnoses (ICD Codes): V POV or Problem List 305.1; 305.1* (old codes); 649.00-649.04; V15.82 [BGP GPRA SMOKING DXS taxonomy]
- V Dental: ADA 1320
- Procedures (CPT Codes): V CPT 1034F, 1035F (BGP TOBACCO USER CPTS taxonomy]

Total Cholesterol Test

- Site defined Lab Tests: V Lab site defined tests in DM AUDIT CHOLESTEROL TAX taxonomy
- LOINC Codes: V Lab as predefined in BGP TOTAL CHOLESTEROL LOINC taxonomy

Note: CPT Codes will not be used to identify this test because a result value is required.

HDL Test

- Site defined Lab Tests: V Lab site defined tests in DM AUDIT HDL TAX taxonomy
- LOINC Codes: V Lab as predefined in BGP HDL LOINC CODES taxonomy

> **Note**: CPT Codes will not be used to identify this test because a result value is required.

LDL Test

- Site defined Lab Tests: V Lab site defined tests in DM AUDIT LDL

CHOLESTEROL TAX taxonomy

- LOINC Codes: V Lab as predefined in BGP LDL LOINC CODES taxonomy

> **Note**: CPT Codes will not be used to identify this test because a result value is required.

Best Practice Prompt Text

Missing information re: CVD Risk Factors: This patient may be at risk for CVD due to gender and age. Currently unable to calculate level of risk for this patient and assist in treatment recommendations because the following data is missing (list specifics).

Site Configurable? No.

B.15 CVD At-Risk: No ASA/Antiplatelets

Description Field Text

Default Status: On

Denominator: Patients with active CVD At-Risk (CVD AR) tag (iCare) with no current prescriptions or contraindications for Aspirin/ASA, Warfarin or other Anti Platelet medications.

Definition (Frequency): As needed when no current prescription.

Logic Detail

CVD At-Risk tag (Proposed or Accepted): If patient is not categorized with Known CVD, CVD At Highest Risk or CVD At Significant and meets the following criteria:

- Male equal to or greater than age 45; or
- Female equal to or greater than age 55

Aspirin/ASA Medications

- Site defined Medications: V Medications in DM AUDIT ASPIRIN DRUGS taxonomy

- NDC (National Drug Codes): V Medications as predefined in BAT ASTHMA INHLD STEROIDS NDC taxonomy

Anti Platelet Medications

- Site defined Medications: V Medications in BGP ANTIPLATELET DRUGS taxonomy
- VA Drug Class: V Medications as predefined in BGP CMS ANTI-PLATELET CLASS NDC taxonomy

Warfarin

- Site defined Medications: V Medications in BGP CMS WARFARIN MEDS

Taxonomy

- NDC (National Drug Codes): V Medications as predefined in BAT ASTHMA INHLD STEROIDS NDC taxonomy
- Medication Contraindications: Defined in RPMS Clinical Reporting System logic document.

Best Practice Prompt Text

CVD Risk: This patient may be at risk for CVD due to gender and age. Consider aspirin therapy, if not contraindicated.

Site Configurable? No.

B.16 CVD Highest Risk: High BP

Description Field Text

Default Status: On

Denominator: Patients with active CVD At Highest Risk (CVD AHR) tag (iCare) with two of last three non-ER blood pressures in past two years are Systolic greater than 130 or Diastolic greater than 80.

Definition (Frequency): As needed when blood pressure is elevated.

Logic Detail

CVD At Highest Risk tag (Proposed or Accepted): if patient is not categorized with Known CVD and meets either of the following criteria:

- Known Diabetes: the patient has two primary diagnosis POVs ever for ambulatory or hospitalization visits (not on the same day) *or* one instance on Active Problem List.

  - Defined as ICD 250.00-250.93 (SURVEILLANCE DIABETES taxonomy); *or*
- End stage renal disease (ESRD) *or* with dialysis: the patient has at least 2 primary diagnosis POVs or procedures ever for ambulatory or hospitalization visits (not on the same day) or one instance on Active Problem List.
  - Defined as ICD 585.5; 585.6, V42.0; V45.1; V56* (BGP ESRD DXS taxonomy); *or*
  - ICD Procedures 38.95; 39.27; 39.42-39.43; 39.53; 39.93-39.95; 54.98; 55.61-55.69 (BGP ESRD PROCS); *or*
  - CPT 36145; 36800; 36810; 36815; 36818-36821; 36831-36833; 50300; 50320; 50340; 50360; 50365; 50370; 50380; 90918-90925; 90935; 90937; 90939; 90940; 90945; 90947; 90989; 90993; 90997; 90999; 99512; G0257; G0308-G0327; S9339 (BGP ESRD CPTS taxonomy).

Best Practice Prompt Text

High BP: At least two recent BP values for this patient were greater than (>) 130/80. Consider more aggressive anti hypertensive therapy.

Site Configurable? No.

B.17 CVD Highest Risk: High LDL

Description Field Text

Default Status: On

Denominator: Patients with active CVD At Highest Risk (AHR) tag (iCare) with most recent LDL test result in the past year greater than 100 *and* with current prescription for Statin medications.

Definition (Frequency): As needed when LDL is high.

Logic Detail

CVD At Highest Risk tag (Proposed or Accepted): if patient is not categorized with Known CVD and meets either of the following criteria:

- Known Diabetes: The patient has two primary diagnosis POVs ever for ambulatory or hospitalization visits (not on the same day) *or* one instance on Active Problem List.
  - Defined as ICD 250.00-250.93 (SURVEILLANCE DIABETES taxonomy); *or*
- ESRD *or* with dialysis: the patient has at least two primary diagnosis POVs or procedures ever for ambulatory or hospitalization visits (not on the same day) or one instance on Active Problem List.

- Defined as ICD: 585.5; 585.6, V42.0; V45.1; V56* (BGP ESRD DXS taxonomy) *or*
- ICD Procedures: 38.95; 39.27; 39.42-39.43; 39.53; 39.93-39.95; 54.98; 55.61-55.69 (BGP ESRD PROCS) *or*
- CPT: 36145; 36800; 36810; 36815; 36818-36821; 36831-36833; 50300; 50320; 50340; 50360; 50365; 50370; 50380; 90918-90925; 90935; 90937; 90939; 90940; 90945; 90947; 90989; 90993; 90997; 90999; 99512; G0257; G0308-G0327; S9339 (BGP ESRD CPTS taxonomy).

LDL Test

- Site defined Lab Tests: V Lab site defined tests in DM AUDIT LDL CHOLESTEROL TAX taxonomy
- LOINC Codes: V Lab as predefined in BGP LDL LOINC CODES taxonomy

Note: CPT Codes will not be used to identify this test because a result value is required.

Statin Medications

Site defined Medications: V Medications in BGP HEDIS STATIN MEDS taxonomy

NDC (National Drug Codes): V Medications as predefined in BGP HEDIS STATIN NDC taxonomy

Best Practice Prompt Text

High LDL: On [date of test], patient's LDL was [xx]. Intensify therapy and reevaluate in two months.

Site Configurable? No.

B.18 CVD Highest Risk: High LDL/No Statin

Description Field Text

Default Status: On

Denominator: Patients with active CVD At Highest Risk (AHR) tag (iCare) with most recent LDL test result in the past year greater than 100 *and* no documented current prescription for Statin medications.

Definition (Frequency): As needed when no current prescription.

Logic Detail

CVD At Highest Risk tag (Proposed or Accepted): if patient is not categorized with Known CVD and meets either of the following criteria:

- Known Diabetes: the patient has two primary diagnosis POVs ever for ambulatory or hospitalization visits (not on the same day) *or* one instance on Active Problem List.
  - Defined as ICD 250.00-250.93 (SURVEILLANCE DIABETES taxonomy); *or*
- ESRD *or* with dialysis: the patient has at least two primary diagnosis POVs or procedures ever for ambulatory or hospitalization visits (not on the same day) or one instance on Active Problem List.
  - Defined as ICD 585.5; 585.6, V42.0; V45.1; V56* (BGP ESRD DXS taxonomy); *or*
  - ICD Procedures 38.95; 39.27; 39.42-39.43; 39.53; 39.93-39.95; 54.98; 55.61-55.69 (BGP ESRD PROCS); *or*
  - CPT 36145; 36800; 36810; 36815; 36818-36821; 36831-36833; 50300; 50320; 50340; 50360; 50365; 50370; 50380; 90918-90925; 90935; 90937; 90939; 90940; 90945; 90947; 90989; 90993; 90997; 90999; 99512; G0257; G0308-G0327; S9339 (BGP ESRD CPTS taxonomy).

LDL Test

- Site defined Lab Tests: V Lab site defined tests in DM AUDIT LDL CHOLESTEROL TAX taxonomy
- LOINC Codes: V Lab as predefined in BGP LDL LOINC CODES taxonomy

Note:	CPT Codes will not be used to identify this test because a result value is required.

Statin Medications

- Site defined Medications: V Medications in BGP HEDIS STATIN MEDS taxonomy
- NDC (National Drug Codes): V Medications as predefined in BGP HEDIS STATIN NDC taxonomy

Best Practice Prompt Text

High LDL: On [date of test], patient's LDL was [xx]. Patient is not documented as currently on a Statin medication. Consider prescribing a Statin medication or another lipid lowering agent, if not contraindicated.

Site Configurable? No.

B.19 CVD Highest Risk: High TG

Description Field Text

Default Status: On

Denominator: Patients with active CVD At Highest Risk (AHR) tag (iCare) with most recent Triglyceride (TG) test result in the past year greater than 150.

Definition (Frequency): As needed.

Logic Detail

CVD At Highest Risk tag (Proposed or Accepted): if patient is not categorized with Known CVD and meets either of the following criteria:

- Known Diabetes: The patient has two primary diagnosis POVs ever for ambulatory or hospitalization visits (not on the same day) *or* one instance on Active Problem List.
  - Defined as ICD 250.00-250.93 (SURVEILLANCE DIABETES taxonomy); *or*
- ESRD *or* with dialysis: the patient has at least two primary diagnosis POVs or procedures ever for ambulatory or hospitalization visits (not on the same day) or one instance on Active Problem List.
  - Defined as ICD 585.5; 585.6, V42.0; V45.1; V56* (BGP ESRD DXS taxonomy); *or*
  - ICD Procedures 38.95; 39.27; 39.42-39.43; 39.53; 39.93-39.95; 54.98; 55.61-55.69 (BGP ESRD PROCS); *or*
  - CPT 36145; 36800; 36810; 36815; 36818-36821; 36831-36833; 50300; 50320; 50340; 50360; 50365; 50370; 50380; 90918-90925; 90935; 90937; 90939; 90940; 90945; 90947; 90989; 90993; 90997; 90999; 99512; G0257; G0308-G0327; S9339 (BGP ESRD CPTS taxonomy).

Triglyceride (TG) Test

- Site defined Lab Tests: V Lab site defined tests in DM AUDIT TRIGLYCERIDE TAX taxonomy
- LOINC Codes: V Lab as predefined in BGP TRIGLYCERIDE LOINC CODES taxonomy

> **Note**: CPT Codes will not be used to identify this test because a result value is required.

Best Practice Prompt Text

High TG: On [date of test], patient's TG was [xx]. Consider fasting lipid profile and/or intensify therapy and reevaluate in two months.

Site Configurable? No.

B.20 CVD Highest Risk: Low HDL

Description Field Text

Default Status: On

Denominator: Patients with active CVD At Highest Risk (AHR) tag (iCare) with most recent HDL result in the past year less than (<) 40.

Definition (Frequency): As needed.

Logic Detail

CVD At Highest Risk tag (Proposed or Accepted): if patient is not categorized with Known CVD and meets either of the following criteria:

- Known Diabetes: The patient has two primary diagnosis POVs ever for ambulatory or hospitalization visits (not on the same day) *or* one instance on Active Problem List.
  - Defined as ICD 250.00-250.93 (SURVEILLANCE DIABETES taxonomy); *or*
- ESRD *or* with dialysis: the patient has at least two primary diagnosis POVs or procedures ever for ambulatory or hospitalization visits (not on the same day) or one instance on Active Problem List.
  - Defined as ICD 585.5; 585.6, V42.0; V45.1; V56* (BGP ESRD DXS taxonomy); *or*
  - ICD Procedures 38.95; 39.27; 39.42-39.43; 39.53; 39.93-39.95; 54.98; 55.61-55.69 (BGP ESRD PROCS); *or*
  - CPT 36145; 36800; 36810; 36815; 36818-36821; 36831-36833; 50300; 50320; 50340; 50360; 50365; 50370; 50380; 90918-90925; 90935; 90937; 90939; 90940; 90945; 90947; 90989; 90993; 90997; 90999; 99512; G0257; G0308-G0327; S9339 (BGP ESRD CPTS taxonomy).

HDL Test

- Site defined Lab Tests: V Lab site defined tests in DM AUDIT HDL TAX taxonomy
- LOINC Codes: V Lab as predefined in BGP HDL LOINC CODES taxonomy

Note:	CPT Codes will not be used to identify this test because a result value is required.

Best Practice Prompt Text

Low HDL: On [date of test], patient's HDL was [xx]. Consider therapeutic lifestyle changes and medical intervention if needed.

Site Configurable? No.

B.21 CVD Highest Risk: No ACEI/ARB

Description Field Text

Default Status: On

Denominator: Patients with active CVD At Highest Risk (CVD AHR) tag (iCare) with no current prescription for ACE Inhibitor or ARB medication **and** any or all of the following conditions:

- Hypertension (HTN): Active Problem List or at least two diagnoses ever, including one in the past year; and/or
- High Blood Pressure: Two of last three non-ER blood pressures in past two years are Systolic => 140 or Diastolic => 90; and/or
- Evidence of Nephropathy in past two years; and/or
- Positive microalbuminuria result in the past year; and/or
- Most recent Estimated GFR result less than 60

Definition (Frequency): As needed.

Logic Detail

CVD At Highest Risk tag (Proposed or Accepted): if patient is not categorized with Known CVD and meets either of the following criteria:

- Known Diabetes: The patient has two primary diagnosis POVs ever for ambulatory or hospitalization visits (not on the same day) or one instance on Active Problem List.
- Defined as ICD 250.00-250.93 (SURVEILLANCE DIABETES taxonomy); *or*
- ESRD *or* with dialysis: the patient has at least two primary diagnosis POVs or procedures ever for ambulatory or hospitalization visits (not on the same day) or one instance on Active Problem List.
  - Defined as ICD 585.5; 585.6, V42.0; V45.1; V56* (BGP ESRD DXS taxonomy); *or*
  - ICD Procedures 38.95; 39.27; 39.42-39.43; 39.53; 39.93-39.95; 54.98; 55.61-55.69 (BGP ESRD PROCS); *or*

- CPT 36145; 36800; 36810; 36815; 36818-36821; 36831-36833; 50300; 50320; 50340; 50360; 50365; 50370; 50380; 90918-90925; 90935; 90937; 90939; 90940; 90945; 90947; 90989; 90993; 90997; 90999; 99512; G0257; G0308-G0327; S9339 (BGP ESRD CPTS taxonomy).

ACE Inhibitor Medications

- Site defined Medications: V Medications in BGP HEDIS ACEI MEDS taxonomy
- NDC (National Drug Codes): V Medications as predefined in BGP HEDIS ACEI NDC taxonomy
- VA Drug Class: V Medications as predefined in BGP CMS ACEI MEDS CLASS taxonomy

ARB Medications

- Site defined Medications: V Medications in BGP HEDIS ARB MEDS taxonomy
- NDC (National Drug Codes): V Medications as predefined in BGP HEDIS ARB NDC taxonomy
- VA Drug Class: V Medications as predefined in BGP CMS ARB MEDS CLASS taxonomy
- ACEI/ARB Contraindications: Defined in RPMS Clinical Reporting System logic document.

Hypertension

- Diagnosis (ICD Codes): V POV or Problem List 401.0-401.9 [BGP HYPERTENSION DXS taxonomy]

Evidence of Nephropathy

- Diagnosis (ICD Codes): Active Problem List or two instances in V POV (not on same day) in past two years 250.40-250.43; 403.0-405.01; 405.11; 405.91; 581.81; 582.9; 583.81; 584.5-586.; 588.0-588.9; 753.0-753.19; 791.0; V42.0; V45.1; V56.0-V56.8 [BGP NEPHROPATHY DXS taxonomy]
- Procedures (ICD Codes): V POV (one in past year) 38.95; 39.27; 39.42-39.43; 39.53; 39.93-39.95; 54.98; 55.4-55.69 [BGP NEPHROPATHY PROCEDURES taxonomy]
- Procedures (CPT Codes): V CPT (one In Past Year) 3066F; 36145; 36800-36815; 36818-36821; 36831-36833; 50300; 50320; 50340; 50360; 50365; 50370-50380; 90920-90921; 90924-90937; 90939-90940; 90945-90947; 90989; 90993; 90997; 90999; 99512; G0257; G0314-G0319; G0322-G0323; G0326-G0327; S9339 [BGP NEPHROPATHY CPTS taxonomy]

Microalbuminuria Test

- Site defined Lab Tests: V Lab site defined tests in DM AUDIT MICROALBUMUNURIA TAX taxonomy
- LOINC Codes: V Lab as predefined in BGP MICROALBUM LOINC CODES taxonomy

> **Note**: CPT Codes will not be used to identify this test because a result value is required.

Estimated GFR

- Site defined Lab Tests: V Lab site defined tests in BGP GPRA ESTIMATED GFR TAX taxonomy

Best Practice Prompt Text

Treatment Recommendation: This patient has the following documented condition(s): [list all conditions that apply]. Consider an ACE Inhibitor or an ARB, if not contraindicated.

Site Configurable? No.

B.22 CVD Highest Risk: No ASA/Antiplatelet

Description Field Text

Default Status: On

Denominator: Patients older than 30 with active CVD At Highest Risk (CVD AHR) tag (iCare) with no current prescriptions or contraindications for Aspirin/ASA, Warfarin or other Anti Platelet medications.

Definition (Frequency): As needed when no current prescription.

Logic Detail

CVD At Highest Risk tag (Proposed or Accepted): if patient is not categorized with Known CVD and meets either of the following criteria:

- Known Diabetes: The patient has two primary diagnosis POVs ever for ambulatory or hospitalization visits (not on the same day) or one instance on Active Problem List.
  - Defined as ICD 250.00-250.93 (SURVEILLANCE DIABETES taxonomy); *or*
- ESRD *or* with dialysis: the patient has at least two primary diagnosis POVs or procedures ever for ambulatory or hospitalization visits (not on the same day) or one instance on Active Problem List.

- Defined as ICD 585.5; 585.6, V42.0; V45.1; V56* (BGP ESRD DXS taxonomy); *or*
- ICD Procedures 38.95; 39.27; 39.42-39.43; 39.53; 39.93-39.95; 54.98; 55.61-55.69 (BGP ESRD PROCS); *or*
- CPT 36145; 36800; 36810; 36815; 36818-36821; 36831-36833; 50300; 50320; 50340; 50360; 50365; 50370; 50380; 90918-90925; 90935; 90937; 90939; 90940; 90945; 90947; 90989; 90993; 90997; 90999; 99512; G0257; G0308-G0327; S9339 (BGP ESRD CPTS taxonomy).

Aspirin/ASA Medications

- Site defined Medications: V Medications in DM AUDIT ASPIRIN DRUGS taxonomy
- NDC (National Drug Codes): V Medications as predefined in BAT ASTHMA INHLD STEROIDS NDC taxonomy

Anti Platelet Medications

- Site defined Medications: V Medications in BGP ANTIPLATELET DRUGS taxonomy
- VA Drug Class: V Medications as predefined in BGP CMS ANTI-PLATELET CLASS NDC taxonomy

Warfarin

- Site defined Medications: V Medications in BGP CMS WARFARIN MEDS taxonomy
- NDC (National Drug Codes)): V Medications as predefined in BAT ASTHMA INHLD STEROIDS NDC taxonomy
- Medication Contraindications: Defined in RPMS Clinical Reporting System logic document.

Best Practice Prompt Text

No ASA prescribed: Patient is over 30 years old and not documented on ASA, Warfarin medications or any other anti-platelet therapy. Consider aspirin or alternative, if not contraindicated.

Site Configurable? No.

B.23 CVD Highest Risk: No EKG Ever

Description Field Text

Default Status: On

Denominator: Patients with active CVD At Highest Risk (AHR) tag (iCare) with no documented EKG ever.

Definition (Frequency): As needed when no EKG is documented.

Logic Detail

CVD At Highest Risk tag (Proposed or Accepted): if patient is not categorized with Known CVD and meets either of the following criteria:

- Known Diabetes: The patient has two primary diagnosis POVs ever for ambulatory or hospitalization visits (not on the same day) or one instance on Active Problem List.
  - Defined as ICD 250.00-250.93 (SURVEILLANCE DIABETES taxonomy); *or*
- ESRD *or* with dialysis: The patient has at least two primary diagnosis POVs or procedures ever for ambulatory or hospitalization visits (not on the same day) or one instance on Active Problem List.
  - Defined as ICD 585.5; 585.6, V42.0; V45.1; V56* (BGP ESRD DXS taxonomy); *or*
  - ICD Procedures 38.95; 39.27; 39.42-39.43; 39.53; 39.93-39.95; 54.98; 55.61-55.69 (BGP ESRD PROCS); *or*
  - CPT 36145; 36800; 36810; 36815; 36818-36821; 36831-36833; 50300; 50320; 50340; 50360; 50365; 50370; 50380; 90918-90925; 90935; 90937; 90939; 90940; 90945; 90947; 90989; 90993; 90997; 90999; 99512; G0257; G0308-G0327; S9339 (BGP ESRD CPTS taxonomy).

EKG

- Procedures (ICD Codes): V Procedure 89.51-89.53 [BQI EKG PROCEDURES taxonomy]

Best Practice Prompt Text

No EKG: Patient has no documented EKG ever. EKG should be ordered.

Site Configurable? No.

B.24 CVD Highest Risk: No Exercise Education

Description Field Text

Default Status: On

Denominator: Patients with active CVD AHR tag (iCare) with no documented exercise education in the past year.

Definition (Frequency): As needed when no exercise education is documented.

Logic Detail

CVD AHR tag (Proposed or Accepted): if patient is not categorized with Known CVD and meets either of the following criteria:

- Known Diabetes: The patient has two primary diagnosis POVs ever for ambulatory or hospitalization visits (not on the same day) or one instance on Active Problem List.
  - Defined as ICD 250.00-250.93 (SURVEILLANCE DIABETES taxonomy); *or*
- End stage renal disease (ESRD) OR with dialysis: The patient has at least two primary diagnosis POVs or procedures ever for ambulatory or hospitalization visits (not on the same day) or one instance on Active Problem List.
  - Defined as ICD 585.5; 585.6, V42.0; V45.1; V56* (BGP ESRD DXS taxonomy); *or*
  - ICD Procedures 38.95; 39.27; 39.42-39.43; 39.53; 39.93-39.95; 54.98; 55.61-55.69 (BGP ESRD PROCS); *or*
  - CPT 36145; 36800; 36810; 36815; 36818-36821; 36831-36833; 50300; 50320; 50340; 50360; 50365; 50370; 50380; 90918-90925; 90935; 90937; 90939; 90940; 90945; 90947; 90989; 90993; 90997; 90999; 99512; G0257; G0308-G0327; S9339 (BGP ESRD CPTS taxonomy).

Exercise Education

- Diagnoses (ICD Codes): V POV V65.41
- Patient Education Codes: V Patient Ed Codes containing “EX”

Best Practice Prompt Text

No Recent Exercise Education: Discuss and document exercise education with this patient.

Site Configurable? No.

B.25 CVD Highest Risk: No LDL

Description Field Text

Default Status: On

Denominator: Patients with active CVD AHR tag (iCare) with no documented LDL test result value in the past year.

Definition (Frequency): As needed.

Logic Detail

CVD AHR tag (Proposed or Accepted): if patient is not categorized with Known CVD and meets either of the following criteria:

- Known Diabetes: The patient has two primary diagnosis POVs ever for ambulatory or hospitalization visits (not on the same day) or one instance on Active Problem List.
  - Defined as ICD 250.00-250.93 (SURVEILLANCE DIABETES taxonomy); *or*
- ESRD *or* with dialysis: The patient has at least two primary diagnosis POVs or procedures ever for ambulatory or hospitalization visits (not on the same day) or one instance on Active Problem List.
  - Defined as ICD 585.5; 585.6, V42.0; V45.1; V56* (BGP ESRD DXS taxonomy); *or*
  - ICD Procedures 38.95; 39.27; 39.42-39.43; 39.53; 39.93-39.95; 54.98; 55.61-55.69 (BGP ESRD PROCS); *or*
  - CPT 36145; 36800; 36810; 36815; 36818-36821; 36831-36833; 50300; 50320; 50340; 50360; 50365; 50370; 50380; 90918-90925; 90935; 90937; 90939; 90940; 90945; 90947; 90989; 90993; 90997; 90999; 99512; G0257; G0308-G0327; S9339 (BGP ESRD CPTS taxonomy).

LDL Test

- Site defined Lab Tests: V Lab site defined tests in DM AUDIT LDL CHOLESTEROL TAX taxonomy
- LOINC Codes: V Lab as predefined in BGP LDL LOINC CODES taxonomy

Note:	CPT Codes will not be used to identify this test because a result value is required.

Best Practice Prompt Text

No LDL: Patient has no documented LDL value in the past year. Needs Lipid evaluation, either fasting lipid or lipid profile with direct LDL.

Site Configurable? No.

B.26 CVD Highest Risk: No Nutrition Education

Description Field Text

Default Status: On

Denominator: Patients with active CVD AHR tag (iCare) with no documented nutrition education in the past year.

Definition (Frequency): As needed when no nutrition education is documented.

Logic Detail

CVD At Highest Risk tag (Proposed or Accepted): if patient is not categorized with Known CVD and meets either of the following criteria:

- Known Diabetes: The patient has two primary diagnosis POVs ever for ambulatory or hospitalization visits (not on the same day) *or* one instance on Active Problem List.
  - Defined as ICD 250.00-250.93 (SURVEILLANCE DIABETES taxonomy); *or*
- ESRD *or* with dialysis: The patient has at least two primary diagnosis POVs or procedures ever for ambulatory or hospitalization visits (not on the same day) or two instance on Active Problem List.
  - Defined as ICD 585.5; 585.6, V42.0; V45.1; V56* (BGP ESRD DXS taxonomy); *or*
  - ICD Procedures 38.95; 39.27; 39.42-39.43; 39.53; 39.93-39.95; 54.98; 55.61-55.69 (BGP ESRD PROCS); *or*
  - CPT 36145; 36800; 36810; 36815; 36818-36821; 36831-36833; 50300; 50320; 50340; 50360; 50365; 50370; 50380; 90918-90925; 90935; 90937; 90939; 90940; 90945; 90947; 90989; 90993; 90997; 90999; 99512; G0257; G0308-G0327; S9339 (BGP ESRD CPTS taxonomy).

Nutrition Education

- Diagnoses (ICD Codes): V POV V65.3
- Patient Education Codes: V Patient Ed Codes containing “N” or “-MNT”

Best Practice Prompt Text

No Recent Nutrition Education: Discuss and document nutrition education with this patient.

Site Configurable? No.

B.27 CVD Highest Risk: No Recent EKG

Description Field Text

Default Status: On

Denominator: Patients with active CVD AHR tag (iCare) with no documented EKG in the past year.

Definition (Frequency): As needed when no recent EKG is documented.

Logic Detail

CVD AHR tag (Proposed or Accepted): if patient is not categorized with Known CVD and meets either of the following criteria:

- Known Diabetes: The patient has two primary diagnosis POVs ever for ambulatory or hospitalization visits (not on the same day) *or* one instance on Active Problem List.
  - Defined as ICD 250.00-250.93 (SURVEILLANCE DIABETES taxonomy); *or*
- ESRD *or* with dialysis: The patient has at least two primary diagnosis POVs or procedures ever for ambulatory or hospitalization visits (not on the same day) or one instance on Active Problem List.
  - Defined as ICD 585.5; 585.6, V42.0; V45.1; V56* (BGP ESRD DXS taxonomy); *or*
  - ICD Procedures 38.95; 39.27; 39.42-39.43; 39.53; 39.93-39.95; 54.98; 55.61-55.69 (BGP ESRD PROCS); *or*
  - CPT 36145; 36800; 36810; 36815; 36818-36821; 36831-36833; 50300; 50320; 50340; 50360; 50365; 50370; 50380; 90918-90925; 90935; 90937; 90939; 90940; 90945; 90947; 90989; 90993; 90997; 90999; 99512; G0257; G0308-G0327; S9339 (BGP ESRD CPTS taxonomy).

EKG

Procedures (ICD Codes): V Procedure 89.51-89.53 [BQI EKG PROCEDURES taxonomy]

Best Practice Prompt Text

No EKG has been documented in past year. EKG is due for this patient.

Site Configurable? No.

B.28 CVD Highest Risk: Smoking Cessation

Description Field Text

Default Status: On

Denominator: Patients with active CVD At Highest Risk (CVD AHR) tag (iCare) who are documented tobacco users (smoker or smokeless) with no documented tobacco intervention after most recent tobacco use diagnosis

Definition (Frequency): As needed when no tobacco intervention is documented.

Logic Detail

CVD AHR tag (Proposed or Accepted): if patient is not categorized with Known CVD and meets either of the following criteria:

- Known Diabetes: The patient has two primary diagnosis POVs ever for ambulatory or hospitalization visits (not on the same day) *or* one instance on Active Problem List.
  - Defined as ICD 250.00-250.93 (SURVEILLANCE DIABETES taxonomy); *or*
- ESRD *or* with dialysis: The patient has at least two primary diagnosis POVs or procedures ever for ambulatory or hospitalization visits (not on the same day) or one instance on Active Problem List.
  - Defined as ICD 585.5; 585.6, V42.0; V45.1; V56* (BGP ESRD DXS taxonomy); *or*
  - ICD Procedures 38.95; 39.27; 39.42-39.43; 39.53; 39.93-39.95; 54.98; 55.61-55.69 (BGP ESRD PROCS); *or*
  - CPT 36145; 36800; 36810; 36815; 36818-36821; 36831-36833; 50300; 50320; 50340; 50360; 50365; 50370; 50380; 90918-90925; 90935; 90937; 90939; 90940; 90945; 90947; 90989; 90993; 90997; 90999; 99512; G0257; G0308-G0327; S9339 (BGP ESRD CPTS taxonomy)

Tobacco Use

- Health Factors: most recent V Health Factor TBD BGP TOBACCO USER HLTH FACTORS taxonomy
- Diagnoses (ICD Codes): V POV or Problem List 305.1; 305.1* (old codes); 649.00-649.04; V15.82 [BGP GPRA SMOKING DXS taxonomy]
- V Dental: ADA 1320
- Procedures (CPT Codes): V CPT 1034F, 1035F (BGP TOBACCO USER CPTS taxonomy]

Tobacco Intervention or Cessation

- Procedures (CPT Codes): V CPT G0375, G0376, 4000F, 4001F [BGP TOBACCO INTERVENTION CPTS taxonomy]
- Clinic: Visit Clinic Code 94 (Tobacco Cessation Clinic)
- Patient Education Codes: V Patient Ed Codes containing “TO-,” “-TO,” “-SHS,” 305.1, 649.00-649.04
- Site defined Medications: V Medications in BGP CMS SMOKING CESSATION MEDS taxonomy or med name containing “Nicotine Patch,” “Nicotine Polacrilex,” “Nicotine Inhaler,” or “Nicotine Nasal Spray”

- NDC (National Drug Codes)): V Medications as predefined in BGP CMS SMOKING CESSATION NDC taxonomy
- V Dental: ADA 1320

Best Practice Prompt Text

Tobacco Cessation: Patient is documented as a current Tobacco User. Consider tobacco cessation intervention.

Site Configurable? No.

B.29 CVD Known: High BP

Description Field Text

Default Status: On

Denominator: Patients with active CVD Known tag (iCare) with two of last three non-ER blood pressures in past two years are Systolic greater than 130 or Diastolic greater than 80 *and* with current prescriptions for both beta blockers *and* ACE Inhibitors (ACEI) or ARB medications.

Definition (Frequency): As needed when blood pressure is elevated.

Logic Detail

CVD Known tag (Proposed or Accepted): The patient is categorized in iCare with Known CVD if any of the following criteria are met:

- One ever of primary diagnosis POV for specific cerebrovascular or peripheral vascular disease diagnoses or procedures for CABG, PCI/PTCA, endarterectomy or carotid stent for ambulatory or hospitalization visits.
  - Defined as ICD 431.*, 433.*1, 434.*1, 435.3, 440.3*, 557.1 (BQI KNOWN CVD-1 DXS taxonomy)for primary diagnosis only;
  - ICD Procedures 36.1*, 36.2 (BGP CABG PROCS taxonomy);
  - CPT 33510-33519; 33521-33523; 33533-33536; 33572; 35600; S2205-S2209 (BGP CABG CPTS taxonomy);
  - ICD V45.81-V45.82 (BGP CMS PCI-PTCA DXS taxonomy);
  - ICD Procedures 36.01, 36.02, 36.05, 36.06, 36.09 (BGP CMS PCI-PTCA PROCEDURES taxonomy);
  - CPT 33140, 92980-92982, 92984, 92995, 92996 (BGP CMS PCI PTCA CPTS taxonomy);
  - ICD Procedures 38.10; 38.12-38.19; 39.50; 39.8*; 39.90 (BQI KNOWN CVD-1 PROCEDURES);
  - CPT 37205-37208; 0075T; 0076T (BQI KNOWN CVD-1 CPTS); **or**

- Two primary diagnosis POVs ever for ambulatory or hospitalization visits (not on the same date) of Acute Myocardial Infarction (AMI) (one instance can be an Active Problem List) at least 90 days apart but no more than two years between first (most recent) and last diagnosis.
  - AMI defined as ICD 410.*0; 410.*1 (BGP AMI DXS (HEDIS) taxonomy); *or*
- Three different POVs of Ischemic Heart Disease (IHD) on same day for ambulatory or hospitalization visit (one POV must be a primary diagnosis; one instance can be an Active Problem List).
  - Defined as ICD 411.*, 413.*, 414.* (BQI IHD DXS taxonomy); *or*
- Three primary diagnosis POV for any IHD or other specific cerebrovascular or peripheral vascular disease diagnoses or procedures for ambulatory or hospitalization visits at least 90 days apart but no more than five years between first and last diagnosis (one instance can be an Active Problem List).
  - Defined as ICD 411.*, 413.*, 414.* (BQI IHD DXS taxonomy);
  - ICD 430.*; 432.*; 433.*; 434.*; 435.*; 436.*; 437.*; 440.*; 441.* (BQI KNOWN CVD-MULT DXS taxonomy);
  - ICD Procedures 38.34, 38.44, 38.64, 39.71 (BQI KNOWN CVD-MULT PROCEDURES taxonomy);
  - CPT 0001T, 0002T, 0033T, 0034T, 0035T, 0036T, 0037T, 33877, 34800, 34802, 34804, 34830, 34831, 34832 (BQI KNOWN CVD-MULT CPTS taxonomy)

Beta Blocker Medication

- Site defined Medications: V Medications in BGP HEDIS BETA BLOCKER MEDS taxonomy
- NDC (National Drug Codes): V Medications as predefined in BGP HEDIS BETA BLOCKER NDC taxonomy
- VA Drug Class: V Medications as predefined in BGP CMS BETA BLOCKER CLASS taxonomy

ACE Inhibitor Medications

- Site defined Medications: V Medications in BGP HEDIS ACEI MEDS taxonomy
- NDC (National Drug Codes): V Medications as predefined in BGP HEDIS ACEI NDC taxonomy
- VA Drug Class: V Medications as predefined in BGP CMS ACEI MEDS CLASS taxonomy

ARB Medications

- Site defined Medications: V Medications in BGP HEDIS ARB MEDS taxonomy
- NDC (National Drug Codes): V Medications as predefined in BGP HEDIS ARB NDC taxonomy
- VA Drug Class: V Medications as predefined in BGP CMS ARB MEDS CLASS taxonomy

Best Practice Prompt Text

High BP: At least two recent BP values for this patient were greater than (>) 130/80. Consider more aggressive anti hypertensive therapy.

Site Configurable? No.

B.30 CVD Known: High LDL

Description Field Text

Default Status: On

Denominator: Patients with active CVD Known tag (iCare) with most recent LDL test result in the past year greater than 100 *and* with current prescription for Statin medications.

Definition (Frequency): As needed when LDL is high.

Logic Detail

CVD Known tag (Proposed or Accepted): The patient is categorized in iCare with Known CVD if any of the following criteria are met:

- One ever of primary diagnosis POV for specific cerebrovascular or peripheral vascular disease diagnoses or procedures for CABG, PCI/PTCA, endarterectomy or carotid stent for ambulatory or hospitalization visits.
  - Defined as ICD 431.*, 433.*1, 434.*1, 435.3, 440.3*, 557.1 (BQI KNOWN CVD-1 DXS taxonomy)for primary diagnosis only
  - ICD Procedures 36.1*, 36.2 (BGP CABG PROCS taxonomy)
  - CPT 33510-33519; 33521-33523; 33533-33536; 33572; 35600; S2205-S2209 (BGP CABG CPTS taxonomy)
  - ICD V45.81-V45.82 (BGP CMS PCI-PTCA DXS taxonomy)
  - ICD Procedures 36.01, 36.02, 36.05, 36.06, 36.09 (BGP CMS PCI-PTCA PROCEDURES taxonomy)
  - CPT 33140, 92980-92982, 92984, 92995, 92996 (BGP CMS PCI PTCA CPTS taxonomy)

  - ICD Procedures 38.10; 38.12-38.19; 39.50; 39.8*; 39.90 (BQI KNOWN CVD-1 PROCEDURES)
  - CPT 37205-37208; 0075T; 0076T (BQI KNOWN CVD-1 CPTS); **or**
- Two primary diagnosis POVs ever for ambulatory or hospitalization visits (not on the same date) of AMI (one instance can be an Active Problem List) at least 90 days apart but no more than two years between first (most recent) and last diagnosis.
  - AMI defined as ICD 410.*0; 410.*1 (BGP AMI DXS (HEDIS) taxonomy); or
- Three different POVs of IHD on same day for ambulatory or hospitalization visit (one POV must be a primary diagnosis; one instance can be an Active Problem List).
  - Defined as ICD 411.*, 413.*, 414.* (BQI IHD DXS taxonomy); *or*
- Three primary diagnosis POV for any IHD or other specific cerebrovascular or peripheral vascular disease diagnoses or procedures for ambulatory or hospitalization visits at least 90 days apart but no more than five years between first and last diagnosis (one instance can be an Active Problem List).
  - Defined as ICD 411.*, 413.*, 414.* (BQI IHD DXS taxonomy)
  - ICD 430.*; 432.*; 433.*; 434.*; 435.*; 436.*; 437.*; 440.*; 441.* (BQI KNOWN CVD-MULT DXS taxonomy)
  - ICD Procedures 38.34, 38.44, 38.64, 39.71 (BQI KNOWN CVD-MULT PROCEDURES taxonomy)
  - CPT 0001T, 0002T, 0033T, 0034T, 0035T, 0036T, 0037T, 33877, 34800, 34802, 34804, 34830, 34831, 34832 (BQI KNOWN CVD-MULT CPTS taxonomy)

LDL Test

- Site defined Lab Tests: V Lab site defined tests in DM AUDIT LDL CHOLESTEROL TAX taxonomy
- LOINC Codes: V Lab as predefined in BGP LDL LOINC CODES taxonomy
- NOTE: CPT Codes will not be used to identify this test because a result value is required.

Statin Medications

- Site defined Medications: V Medications in BGP HEDIS STATIN MEDS taxonomy
- NDC (National Drug Codes): V Medications as predefined in BGP HEDIS STATIN NDC taxonomy

Best Practice Prompt Text

High LDL: On [date of test], patient's LDL was [xx]. Intensify therapy and reevaluate in 2 months.

Site Configurable? No.

B.31 CVD Known: High TG

Description Field Text

Default Status: On

Denominator: Patients with active CVD Known tag (iCare) with most recent Triglyceride (TG) test result in the past year greater than 150.

Definition (Frequency): As needed.

Logic Detail

CVD Known tag (Proposed or Accepted): The patient is categorized in iCare with Known CVD if any of the following criteria are met:

- One ever of primary diagnosis POV for specific cerebrovascular or peripheral vascular disease diagnoses or procedures for CABG, PCI/PTCA, endarterectomy or carotid stent for ambulatory or hospitalization visits.
  - Defined as ICD 431.*, 433.*1, 434.*1, 435.3, 440.3*, 557.1 (BQI KNOWN CVD-1 DXS taxonomy)for primary diagnosis only;
  - ICD Procedures 36.1*, 36.2 (BGP CABG PROCS taxonomy);
  - CPT 33510-33519; 33521-33523; 33533-33536; 33572; 35600; S2205-S2209 (BGP CABG CPTS taxonomy);
  - ICD V45.81-V45.82 (BGP CMS PCI-PTCA DXS taxonomy);
  - ICD Procedures 36.01, 36.02, 36.05, 36.06, 36.09 (BGP CMS PCI-PTCA PROCEDURES taxonomy);
  - CPT 33140, 92980-92982, 92984, 92995, 92996 (BGP CMS PCI PTCA CPTS taxonomy);
  - ICD Procedures 38.10; 38.12-38.19; 39.50; 39.8*; 39.90 (BQI KNOWN CVD-1 PROCEDURES);
  - CPT 37205-37208; 0075T; 0076T (BQI KNOWN CVD-1 CPTS); OR
- Two primary diagnosis POVs ever for ambulatory or hospitalization visits (not on the same date) of AMI (one instance can be an Active Problem List) at least 90 days apart but no more than two years between first (most recent) and last diagnosis.
  - AMI defined as ICD 410.*0; 410.*1 (BGP AMI DXS (HEDIS) taxonomy); *or*

- Three different POVs of IHD on same day for ambulatory or hospitalization visit (one POV must be a primary diagnosis; one instance can be an Active Problem List);
  - Defined as ICD 411.*, 413.*, 414.* (BQI IHD DXS taxonomy); *or*
- Three primary diagnosis POV for any IHD or other specific cerebrovascular or peripheral vascular disease diagnoses or procedures for ambulatory or hospitalization visits at least 90 days apart but no more than five years between first and last diagnosis (one instance can be an Active Problem List).
  - Defined as ICD 411.*, 413.*, 414.* (BQI IHD DXS taxonomy);
  - ICD 430.*; 432.*; 433.*; 434.*; 435.*; 436.*; 437.*; 440.*; 441.* (BQI KNOWN CVD-MULT DXS taxonomy);
  - ICD Procedures 38.34, 38.44, 38.64, 39.71 (BQI KNOWN CVD-MULT PROCEDURES taxonomy);
  - CPT 0001T, 0002T, 0033T, 0034T, 0035T, 0036T, 0037T, 33877, 34800, 34802, 34804, 34830, 34831, 34832 (BQI KNOWN CVD-MULT CPTS taxonomy).

Triglyceride (TG) Test

- Site defined Lab Tests: V Lab site defined tests in DM AUDIT TRIGLYCERIDE TAX taxonomy
- LOINC Codes: V Lab as predefined in BGP TRIGLYCERIDE LOINC CODES taxonomy

Note	CPT Codes will not be used to identify this test because a result value is required.

Best Practice Prompt Text

High TG: On [date of test], patient's TG was [xx]. Consider fasting lipid profile and/or intensify therapy and reevaluate in 2 months.

Site Configurable? No.

B.32 CVD Known: Low HDL

Description Field Text

Default Status: On

Denominator: Patients with active CVD Known tag (iCare) with most recent LDL test result in the past year equal to or less than (=<) 100 *and* most recent HDL result in the past year less than (<) 40.

Definition (Frequency): As needed.

Logic Detail

CVD Known tag (Proposed or Accepted): The patient is categorized in iCare with Known CVD if any of the following criteria are met:

- One ever of primary diagnosis POV for specific cerebrovascular or peripheral vascular disease diagnoses or procedures for CABG, PCI/PTCA, endarterectomy or carotid stent for ambulatory or hospitalization visits.
  - Defined as ICD 431.*, 433.*1, 434.*1, 435.3, 440.3*, 557.1 (BQI KNOWN CVD-1 DXS taxonomy) for primary diagnosis only;
  - ICD Procedures 36.1*, 36.2 (BGP CABG PROCS taxonomy); CPT 33510-33519; 33521-33523; 33533-33536; 33572; 35600; S2205-S2209 (BGP CABG CPTS taxonomy);
  - ICD V45.81-V45.82 (BGP CMS PCI-PTCA DXS taxonomy);
  - ICD Procedures 36.01, 36.02, 36.05, 36.06, 36.09 (BGP CMS PCI-PTCA PROCEDURES taxonomy);
  - CPT 33140, 92980-92982, 92984, 92995, 92996 (BGP CMS PCI PTCA CPTS taxonomy);
  - ICD Procedures 38.10; 38.12-38.19; 39.50; 39.8*; 39.90 (BQI KNOWN CVD-1 PROCEDURES);
  - CPT 37205-37208; 0075T; 0076T (BQI KNOWN CVD-1 CPTS); **or**
- Two primary diagnosis POVs ever for ambulatory or hospitalization visits (not on the same date) of AMI (one instance can be an Active Problem List) at least 90 days apart but no more than two years between first (most recent) and last diagnosis.
  - AMI defined as ICD 410.*0; 410.*1 (BGP AMI DXS (HEDIS) taxonomy); **or**
- Three different POVs of IHD on same day for ambulatory or hospitalization visit (one POV must be a primary diagnosis; one instance can be an Active Problem List).
  - Defined as ICD 411.*, 413.*, 414.* (BQI IHD DXS taxonomy); **or**
- Three primary diagnosis POV for any IHD or other specific cerebrovascular or peripheral vascular disease diagnoses or procedures for ambulatory or hospitalization visits at least 90 days apart but no more than five years between first and last diagnosis (one instance can be an Active Problem List).
  - Defined as ICD 411.*, 413.*, 414.* (BQI IHD DXS taxonomy);
  - ICD 430.*; 432.*; 433.*; 434.*; 435.*; 436.*; 437.*; 440.*; 441.* (BQI KNOWN CVD-MULT DXS taxonomy);
  - ICD Procedures 38.34, 38.44, 38.64, 39.71 (BQI KNOWN CVD-MULT PROCEDURES taxonomy);

– CPT 0001T, 0002T, 0033T, 0034T, 0035T, 0036T, 0037T, 33877, 34800, 34802, 34804, 34830, 34831, 34832 (BQI KNOWN CVD-MULT CPTS taxonomy)

LDL Test

- Site defined Lab Tests: V Lab site defined tests in DM AUDIT LDL CHOLESTEROL TAX taxonomy
- LOINC Codes: V Lab as predefined in BGP LDL LOINC CODES taxonomy

Note: CPT Codes will not be used to identify this test because a result value is required.

HDL Test

- Site defined Lab Tests: V Lab site defined tests in DM AUDIT HDL TAX taxonomy
- LOINC Codes: V Lab as predefined in BGP HDL LOINC CODES taxonomy

Note CPT Codes will not be used to identify this test because a result value is required.

Best Practice Prompt Text

Low HDL: On [date of test], patient's HDL was [xx]. Consider therapeutic lifestyle changes and medical intervention if needed.

Site Configurable? No.

B.33 CVD Known: No ACEI/ARB

Description Field Text

Default Status: On

Denominator: Patients with active CVD Known tag (iCare) with two of last three non-ER blood pressures in past two years are Systolic greater than 130 or Diastolic greater than 80 *and* with no current prescriptions or contraindications for ACEI or ARB medications.

Definition (Frequency): As needed when no current prescription.

Logic Detail

CVD Known tag (Proposed or Accepted): The patient is categorized in iCare with Known CVD if any of the following criteria are met:

- One ever of primary diagnosis POV for specific cerebrovascular or peripheral vascular disease diagnoses or procedures for CABG, PCI/PTCA, endarterectomy or carotid stent for ambulatory or hospitalization visits.
  - Defined as ICD 431.*, 433.*1, 434.*1, 435.3, 440.3*, 557.1 (BQI KNOWN CVD-1 DXS taxonomy)for primary diagnosis only;
  - ICD Procedures 36.1*, 36.2 (BGP CABG PROCS taxonomy); CPT 33510-33519; 33521-33523; 33533-33536; 33572; 35600; S2205-S2209 (BGP CABG CPTS taxonomy);
  - ICD V45.81-V45.82 (BGP CMS PCI-PTCA DXS taxonomy);
  - ICD Procedures 36.01, 36.02, 36.05, 36.06, 36.09 (BGP CMS PCI-PTCA PROCEDURES taxonomy);
  - CPT 33140, 92980-92982, 92984, 92995, 92996 (BGP CMS PCI PTCA CPTS taxonomy);
  - ICD Procedures 38.10; 38.12-38.19; 39.50; 39.8*; 39.90 (BQI KNOWN CVD-1 PROCEDURES);
  - CPT 37205-37208; 0075T; 0076T (BQI KNOWN CVD-1 CPTS); **or**
- Two primary diagnosis POVs ever for ambulatory or hospitalization visits (not on the same date) of AMI (one instance can be an Active Problem List) at least 90 days apart but no more than two years between first (most recent) and last diagnosis.
  - AMI defined as ICD 410.*0; 410.*1 (BGP AMI DXS (HEDIS) taxonomy); **or**
- Three different POVs of IHD on same day for ambulatory or hospitalization visit (one POV must be a primary diagnosis; one instance can be an Active Problem List).
  - Defined as ICD 411.*, 413.*, 414.* (BQI IHD DXS taxonomy); **or**
- Three primary diagnosis POV for any IHD or other specific cerebrovascular or peripheral vascular disease diagnoses or procedures for ambulatory or hospitalization visits at least 90 days apart but no more than five years between first and last diagnosis (one instance can be an Active Problem List).
  - Defined as ICD 411.*, 413.*, 414.* (BQI IHD DXS taxonomy);
  - ICD 430.*; 432.*; 433.*; 434.*; 435.*; 436.*; 437.*; 440.*; 441.* (BQI KNOWN CVD-MULT DXS taxonomy);
  - ICD Procedures 38.34, 38.44, 38.64, 39.71 (BQI KNOWN CVD-MULT PROCEDURES taxonomy);
  - CPT 0001T, 0002T, 0033T, 0034T, 0035T, 0036T, 0037T, 33877, 34800, 34802, 34804, 34830, 34831, 34832 (BQI KNOWN CVD-MULT CPTS taxonomy)

ACE Inhibitor Medications

- Site defined Medications: V Medications in BGP HEDIS ACEI MEDS taxonomy
- NDC (National Drug Codes): V Medications as predefined in BGP HEDIS ACEI NDC taxonomy
- VA Drug Class: V Medications as predefined in BGP CMS ACEI MEDS CLASS taxonomy

ARB Medications

- Site defined Medications: V Medications in BGP HEDIS ARB MEDS taxonomy
- NDC (National Drug Codes): V Medications as predefined in BGP HEDIS ARB NDC taxonomy
- VA Drug Class: V Medications as predefined in BGP CMS ARB MEDS CLASS taxonomy
- ACEI/ARB Contraindications: Defined in RPMS Clinical Reporting System logic document.

Best Practice Prompt Text

No ACEI/ARB prescribed: Patient is not documented as currently on an ACEI or ARB medication. This patient should be on an ACE Inhibitor or ARB, if not contraindicated.

Site Configurable? No.

B.34 CVD Known: No ASA/Antiplatelet

Description Field Text

Default Status: On

Denominator: Patients with active CVD Known tag (iCare) with no current prescriptions or contraindications for Aspirin/ASA, Warfarin or other Anti Platelet medications.

Definition (Frequency): As needed when no current prescription.

Logic Detail

CVD Known tag (Proposed or Accepted): The patient is categorized in iCare with Known CVD if any of the following criteria are met:

- One ever of primary diagnosis POV for specific cerebrovascular or peripheral vascular disease diagnoses or procedures for CABG, PCI/PTCA, endarterectomy or carotid stent for ambulatory or hospitalization visits.

  - Defined as ICD 431.*, 433.*1, 434.*1, 435.3, 440.3*, 557.1 (BQI KNOWN CVD-1 DXS taxonomy)for primary diagnosis only;
  - ICD Procedures 36.1*, 36.2 (BGP CABG PROCS taxonomy);
  - CPT 33510-33519; 33521-33523; 33533-33536; 33572; 35600; S2205-S2209 (BGP CABG CPTS taxonomy);
  - ICD V45.81-V45.82 (BGP CMS PCI-PTCA DXS taxonomy);
  - ICD Procedures 36.01, 36.02, 36.05, 36.06, 36.09 (BGP CMS PCI-PTCA PROCEDURES taxonomy);
  - CPT 33140, 92980-92982, 92984, 92995, 92996 (BGP CMS PCI PTCA CPTS taxonomy);
  - ICD Procedures 38.10; 38.12-38.19; 39.50; 39.8*; 39.90 (BQI KNOWN CVD-1 PROCEDURES);
  - CPT 37205-37208; 0075T; 0076T (BQI KNOWN CVD-1 CPTS); **or**
- Two primary diagnosis POVs ever for ambulatory or hospitalization visits (not on the same date) of AMI (one instance can be an Active Problem List) at least 90 days apart but no more than two years between first (most recent) and last diagnosis.
  - AMI defined as ICD 410.*0; 410.*1 (BGP AMI DXS (HEDIS) taxonomy); *or*
- Three different POVs of IHD on same day for ambulatory or hospitalization visit (one POV must be a primary diagnosis; one instance can be an Active Problem List).
  - Defined as ICD 411.*, 413.*, 414.* (BQI IHD DXS taxonomy); *or*
- Three primary diagnosis POV for any IHD or other specific cerebrovascular or peripheral vascular disease diagnoses or procedures for ambulatory or hospitalization visits at least 90 days apart but no more than five years between first and last diagnosis (one instance can be an Active Problem List).
  - Defined as ICD 411.*, 413.*, 414.* (BQI IHD DXS taxonomy);
  - ICD 430.*; 432.*; 433.*; 434.*; 435.*; 436.*; 437.*; 440.*; 441.* (BQI KNOWN CVD-MULT DXS taxonomy);
  - ICD Procedures 38.34, 38.44, 38.64, 39.71 (BQI KNOWN CVD-MULT PROCEDURES taxonomy);
  - CPT 0001T, 0002T, 0033T, 0034T, 0035T, 0036T, 0037T, 33877, 34800, 34802, 34804, 34830, 34831, 34832 (BQI KNOWN CVD-MULT CPTS taxonomy)

Aspirin/ASA Medications

- Site defined Medications: V Medications in DM AUDIT ASPIRIN DRUGS taxonomy

- NDC (National Drug Codes)): V Medications as predefined in BAT ASTHMA INHLD STEROIDS NDC taxonomy

Anti Platelet Medications

- Site defined Medications: V Medications in BGP ANTIPLATELET DRUGS taxonomy
- VA Drug Class: V Medications as predefined in BGP CMS ANTI-PLATELET CLASS NDC taxonomy
- Warfarin - Site defined Medications: V Medications in BGP CMS WARFARIN MEDS taxonomy
- NDC (National Drug Codes): V Medications as predefined in BAT ASTHMA INHLD STEROIDS NDC taxonomy Medication Contraindications: Defined in RPMS Clinical Reporting System logic document.

Best Practice Prompt Text

No ASA prescribed: Patient is not documented as being on ASA, Warfarin medications or any other anti platelet therapy consider aspirin or alternative, if not contraindicated.

Site Configurable? No.

B.35 CVD Known: No Beta Blocker

Description Field Text

Default Status: On

Denominator: Patients with active CVD Known tag (iCare) with two of last three non-ER blood pressures in past two years are Systolic greater than 130 or Diastolic greater than 80 *and* with no current prescriptions or contraindications for beta blocker medications.

Definition (Frequency): As needed when no current prescription.

LOGIC DETAIL

CVD Known tag (Proposed or Accepted): The patient is categorized in iCare with Known CVD if any of the following criteria are met:

- One ever of primary diagnosis POV for specific cerebrovascular or peripheral vascular disease diagnoses or procedures for CABG, PCI/PTCA, endarterectomy or carotid stent for ambulatory or hospitalization visits.
  - Defined as ICD 431.*, 433.*1, 434.*1, 435.3, 440.3*, 557.1 (BQI KNOWN CVD-1 DXS taxonomy)for primary diagnosis only;
  - ICD Procedures 36.1*, 36.2 (BGP CABG PROCS taxonomy);

  - CPT 33510-33519; 33521-33523; 33533-33536; 33572; 35600; S2205-S2209 (BGP CABG CPTS taxonomy);
  - ICD V45.81-V45.82 (BGP CMS PCI-PTCA DXS taxonomy);
  - ICD Procedures 36.01, 36.02, 36.05, 36.06, 36.09 (BGP CMS PCI-PTCA PROCEDURES taxonomy);
  - CPT 33140, 92980-92982, 92984, 92995, 92996 (BGP CMS PCI PTCA CPTS taxonomy);
  - ICD Procedures 38.10; 38.12-38.19; 39.50; 39.8*; 39.90 (BQI KNOWN CVD-1 PROCEDURES);
  - CPT 37205-37208; 0075T; 0076T (BQI KNOWN CVD-1 CPTS); **or**
- Two primary diagnosis POVs ever for ambulatory or hospitalization visits (not on the same date) of AMI (one instance can be an Active Problem List) at least 90 days apart but no more than two years between first (most recent) and last diagnosis.
  - AMI defined as ICD 410.*0; 410.*1 (BGP AMI DXS (HEDIS) taxonomy); *or*
- Three different POVs of IHD on same day for ambulatory or hospitalization visit (one POV must be a primary diagnosis; one instance can be an Active Problem List).
  - Defined as ICD 411.*, 413.*, 414.* (BQI IHD DXS taxonomy); **or**
- Three primary diagnosis POV for any IHD or other specific cerebrovascular or peripheral vascular disease diagnoses or procedures for ambulatory or hospitalization visits at least 90 days apart but no more than five years between first and last diagnosis (one instance can be an Active Problem List).
- Defined as ICD 411.*, 413.*, 414.* (BQI IHD DXS taxonomy);
- ICD 430.*; 432.*; 433.*; 434.*; 435.*; 436.*; 437.*; 440.*; 441.* (BQI KNOWN CVD-MULT DXS taxonomy);
- ICD Procedures 38.34, 38.44, 38.64, 39.71 (BQI KNOWN CVD-MULT PROCEDURES taxonomy);
- CPT 0001T, 0002T, 0033T, 0034T, 0035T, 0036T, 0037T, 33877, 34800, 34802, 34804, 34830, 34831, 34832 (BQI KNOWN CVD-MULT CPTS taxonomy)

Beta Blocker Medications

- Site defined Medications: V Medications in BGP HEDIS BETA BLOCKER MEDS taxonomy
- NDC (National Drug Codes): V Medications as predefined in BGP HEDIS BETA BLOCKER NDC taxonomy

- VA Drug Class: V Medications as predefined in BGP CMS BETA BLOCKER CLASS taxonomy Beta Blocker Contraindications: Defined in RPMS Clinical Reporting System logic document.

Best Practice Prompt Text

No Beta Blocker prescribed: Patient is not documented as currently on a beta blocker medication. This patient should be on a beta blocker, if not contraindicated.

B.36 CVD Known: No Exercise Education

Description Field Text

Default Status: On

Denominator: Patients with active CVD Known tag (iCare) with no documented exercise education in the past year.

Definition (Frequency): As needed when no exercise education is documented.

Logic Detail

CVD Known tag (Proposed or Accepted): The patient is categorized in iCare with Known CVD if any of the following criteria are met:

- One ever of primary diagnosis POV for specific cerebrovascular or peripheral vascular disease diagnoses or procedures for CABG, PCI/PTCA, endarterectomy or carotid stent for ambulatory or hospitalization visits.
  - Defined as ICD 431.*, 433.*1, 434.*1, 435.3, 440.3*, 557.1 (BQI KNOWN CVD-1 DXS taxonomy)for primary diagnosis only;
  - ICD Procedures 36.1*, 36.2 (BGP CABG PROCS taxonomy);
  - CPT 33510-33519; 33521-33523; 33533-33536; 33572; 35600; S2205-S2209 (BGP CABG CPTS taxonomy);
  - ICD V45.81-V45.82 (BGP CMS PCI-PTCA DXS taxonomy);
  - ICD Procedures 36.01, 36.02, 36.05, 36.06, 36.09 (BGP CMS PCI-PTCA PROCEDURES taxonomy);
  - CPT 33140, 92980-92982, 92984, 92995, 92996 (BGP CMS PCI PTCA CPTS taxonomy);
  - ICD Procedures 38.10; 38.12-38.19; 39.50; 39.8*; 39.90 (BQI KNOWN CVD-1 PROCEDURES);
  - CPT 37205-37208; 0075T; 0076T (BQI KNOWN CVD-1 CPTS); **or**
- Two primary diagnosis POVs ever for ambulatory or hospitalization visits (not on the same date) of AMI (one instance can be an Active Problem List) at least 90 days apart but no more than two years between first (most recent) and last diagnosis.

  - AMI defined as ICD 410.*0; 410.*1 (BGP AMI DXS (HEDIS) taxonomy); *or*
- Three different POVs of IHD on same day for ambulatory or hospitalization visit (one POV must be a primary diagnosis; one instance can be an Active Problem List).
  - Defined as ICD 411.*, 413.*, 414.* (BQI IHD DXS taxonomy); *or*
- Three primary diagnosis POV for any IHD or other specific cerebrovascular or peripheral vascular disease diagnoses or procedures for ambulatory or hospitalization visits at least 90 days apart but no more than five years between first and last diagnosis (one instance can be an Active Problem List).
  - Defined as ICD 411.*, 413.*, 414.* (BQI IHD DXS taxonomy);
  - ICD 430.*; 432.*; 433.*; 434.*; 435.*; 436.*; 437.*; 440.*; 441.* (BQI KNOWN CVD-MULT DXS taxonomy);
  - ICD Procedures 38.34, 38.44, 38.64, 39.71 (BQI KNOWN CVD-MULT PROCEDURES taxonomy);
  - CPT 0001T, 0002T, 0033T, 0034T, 0035T, 0036T, 0037T, 33877, 34800, 34802, 34804, 34830, 34831, 34832 (BQI KNOWN CVD-MULT CPTS taxonomy)

Exercise Education

Diagnoses (ICD Codes): V POV V65.41

Patient Education Codes: V Patient Ed Codes containing “EX”

Best Practice Prompt Text

No Recent Exercise Education: Discuss and document exercise education with this patient.

Site Configurable? No.

B.37 CVD Known: No LDL

Description Field Text

Default Status: On

Denominator: Patients with active CVD Known tag (iCare) with no documented LDL test result value in the past year.

Definition (Frequency): As needed.

Logic Detail

CVD Known tag (Proposed or Accepted): The patient is categorized in iCare with Known CVD if any of the following criteria are met:

- One ever of primary diagnosis POV for specific cerebrovascular or peripheral vascular disease diagnoses or procedures for CABG, PCI/PTCA, endarterectomy or carotid stent for ambulatory or hospitalization visits.
  - Defined as ICD 431.*, 433.*1, 434.*1, 435.3, 440.3*, 557.1 (BQI KNOWN CVD-1 DXS taxonomy) for primary diagnosis only;
  - ICD Procedures 36.1*, 36.2 (BGP CABG PROCS taxonomy);
  - CPT 33510-33519; 33521-33523; 33533-33536; 33572; 35600; S2205-S2209 (BGP CABG CPTS taxonomy);
  - ICD V45.81-V45.82 (BGP CMS PCI-PTCA DXS taxonomy);
  - ICD Procedures 36.01, 36.02, 36.05, 36.06, 36.09 (BGP CMS PCI-PTCA PROCEDURES taxonomy);
  - CPT 33140, 92980-92982, 92984, 92995, 92996 (BGP CMS PCI PTCA CPTS taxonomy);
  - ICD Procedures 38.10; 38.12-38.19; 39.50; 39.8*; 39.90 (BQI KNOWN CVD-1 PROCEDURES); CPT 37205-37208; 0075T; 0076T (BQI KNOWN CVD-1 CPTS); *or*
- Two primary diagnosis POVs ever for ambulatory or hospitalization visits (not on the same date) of AMI (one instance can be an Active Problem List) at least 90 days apart but no more than two years between first (most recent) and last diagnosis.
  - AMI defined as ICD 410.*0; 410.*1 (BGP AMI DXS (HEDIS) taxonomy); *or*
- Three different POVs of IHD on same day for ambulatory or hospitalization visit (one POV must be a primary diagnosis; one instance can be an Active Problem List).
  - Defined as ICD 411.*, 413.*, 414.* (BQI IHD DXS taxonomy); *or*
- Three primary diagnosis POV for any IHD or other specific cerebrovascular or peripheral vascular disease diagnoses or procedures for ambulatory or hospitalization visits at least 90 days apart but no more than five years between first and last diagnosis (one instance can be an Active Problem List).
  - Defined as ICD 411.*, 413.*, 414.* (BQI IHD DXS taxonomy);
  - ICD 430.*; 432.*; 433.*; 434.*; 435.*; 436.*; 437.*; 440.*; 441.* (BQI KNOWN CVD-MULT DXS taxonomy);
  - ICD Procedures 38.34, 38.44, 38.64, 39.71 (BQI KNOWN CVD-MULT PROCEDURES taxonomy);
  - CPT 0001T, 0002T, 0033T, 0034T, 0035T, 0036T, 0037T, 33877, 34800, 34802, 34804, 34830, 34831, 34832 (BQI KNOWN CVD-MULT CPTS taxonomy).

LDL Test

- Site defined Lab Tests: V Lab site defined tests in DM AUDIT LDL CHOLESTEROL TAX taxonomy
- LOINC Codes: V Lab as predefined in BGP LDL LOINC CODES taxonomy

> **Note**: CPT Codes will not be used to identify this test because a result value is required.

Best Practice Prompt Text

No LDL: Patient has no documented LDL value in the past year. Needs Lipid evaluation, either fasting lipid or lipid profile with direct LDL.

Site Configurable? No.

B.38 CVD Known: No Nutrition Education

Description Field Text

Default Status: On

Denominator: Patients with active CVD Known tag (iCare) with no documented nutrition education in the past year.

Definition (Frequency): As needed when no nutrition education is documented.

Logic Detail

CVD Known tag (Proposed or Accepted): The patient is categorized in iCare with Known CVD if any of the following criteria are met:

- One ever of primary diagnosis POV for specific cerebrovascular or peripheral vascular disease diagnoses or procedures for CABG, PCI/PTCA, endarterectomy or carotid stent for ambulatory or hospitalization visits.
  - Defined as ICD 431.*, 433.*1, 434.*1, 435.3, 440.3*, 557.1 (BQI KNOWN CVD-1 DXS taxonomy)for primary diagnosis only;
  - ICD Procedures 36.1*, 36.2 (BGP CABG PROCS taxonomy);
  - CPT 33510-33519; 33521-33523; 33533-33536; 33572; 35600; S2205-S2209 (BGP CABG CPTS taxonomy);
  - ICD V45.81-V45.82 (BGP CMS PCI-PTCA DXS taxonomy);
  - ICD Procedures 36.01, 36.02, 36.05, 36.06, 36.09 (BGP CMS PCI-PTCA PROCEDURES taxonomy);
  - CPT 33140, 92980-92982, 92984, 92995, 92996 (BGP CMS PCI PTCA CPTS taxonomy);
  - ICD Procedures 38.10; 38.12-38.19; 39.50; 39.8*; 39.90 (BQI KNOWN CVD-1 PROCEDURES);
  - CPT 37205-37208; 0075T; 0076T (BQI KNOWN CVD-1 CPTS); *or*

  - Two primary diagnosis POVs ever for ambulatory or hospitalization visits (not on the same date) of AMI (one instance can be an Active Problem List) at least 90 days apart but no more than 2 years between first (most recent) and last diagnosis.
- AMI defined as ICD 410.*0; 410.*1 (BGP AMI DXS (HEDIS) taxonomy); *or*
- Three different POVs of IHD on same day for ambulatory or hospitalization visit (one POV must be a primary diagnosis; one instance can be an Active Problem List).
  - Defined as ICD 411.*, 413.*, 414.* (BQI IHD DXS taxonomy); *or*
- Three primary diagnosis POV for any IHD or other specific cerebrovascular or peripheral vascular disease diagnoses or procedures for ambulatory or hospitalization visits at least 90 days apart but no more than 5 years between first and last diagnosis (one instance can be an Active Problem List).
  - Defined as ICD 411.*, 413.*, 414.* (BQI IHD DXS taxonomy);
  - ICD 430.*; 432.*; 433.*; 434.*; 435.*; 436.*; 437.*; 440.*; 441.* (BQI KNOWN CVD-MULT DXS taxonomy);
  - ICD Procedures 38.34, 38.44, 38.64, 39.71 (BQI KNOWN CVD-MULT PROCEDURES taxonomy);
  - CPT 0001T, 0002T, 0033T, 0034T, 0035T, 0036T, 0037T, 33877, 34800, 34802, 34804, 34830, 34831, 34832 (BQI KNOWN CVD-MULT CPTS taxonomy).

Nutrition Education

- Diagnoses (ICD Codes): V POV V65.3
- Patient Education Codes: V Patient Ed Codes containing “N” or “-MNT”

Best Practice Prompt Text

No Recent Nutrition Education: Discuss and document nutrition education with this patient.

Site Configurable? No.

B.39 CVD Known: No Recent EKG

Description Field Text

Default Status: On

Denominator: Patients with active CVD Known tag (iCare) with no documented EKG in the past year.

Definition (Frequency): As needed when no recent EKG is documented.

Logic Detail

CVD Known tag (Proposed or Accepted): The patient is categorized in iCare with Known CVD if any of the following criteria are met:

- One ever of primary diagnosis POV for specific cerebrovascular or peripheral vascular disease diagnoses or procedures for CABG, PCI/PTCA, endarterectomy or carotid stent for ambulatory or hospitalization visits.
  - Defined as ICD 431.*, 433.*1, 434.*1, 435.3, 440.3*, 557.1 (BQI KNOWN CVD-1 DXS taxonomy)for primary diagnosis only;
  - ICD Procedures 36.1*, 36.2 (BGP CABG PROCS taxonomy);
  - CPT 33510-33519; 33521-33523; 33533-33536; 33572; 35600; S2205-S2209 (BGP CABG CPTS taxonomy);
  - ICD V45.81-V45.82 (BGP CMS PCI-PTCA DXS taxonomy);
  - ICD Procedures 36.01, 36.02, 36.05, 36.06, 36.09 (BGP CMS PCI-PTCA PROCEDURES taxonomy);
  - CPT 33140, 92980-92982, 92984, 92995, 92996 (BGP CMS PCI PTCA CPTS taxonomy);
  - ICD Procedures 38.10; 38.12-38.19; 39.50; 39.8*; 39.90 (BQI KNOWN CVD-1 PROCEDURES);
  - CPT 37205-37208; 0075T; 0076T (BQI KNOWN CVD-1 CPTS); *or*
- Two primary diagnosis POVs ever for ambulatory or hospitalization visits (not on the same date) of AMI (one instance can be an Active Problem List) at least 90 days apart but no more than 2 years between first (most recent) and last diagnosis.
  - AMI defined as ICD 410.*0; 410.*1 (BGP AMI DXS (HEDIS) taxonomy); *or*
- Three different POVs of IHD on same day for ambulatory or hospitalization visit (one POV must be a primary diagnosis; one instance can be an Active Problem List);
  - Defined as ICD 411.*, 413.*, 414.* (BQI IHD DXS taxonomy); *or*
- Three primary diagnosis POV for any IHD or other specific cerebrovascular or peripheral vascular disease diagnoses or procedures for ambulatory or hospitalization visits at least 90 days apart but no more than 5 years between first and last diagnosis (one instance can be an Active Problem List).
  - Defined as ICD 411.*, 413.*, 414.* (BQI IHD DXS taxonomy);
  - ICD 430.*; 432.*; 433.*; 434.*; 435.*; 436.*; 437.*; 440.*; 441.* (BQI KNOWN CVD-MULT DXS taxonomy);
  - ICD Procedures 38.34, 38.44, 38.64, 39.71 (BQI KNOWN CVD-MULT PROCEDURES taxonomy);

- CPT 0001T, 0002T, 0033T, 0034T, 0035T, 0036T, 0037T, 33877, 34800, 34802, 34804, 34830, 34831, 34832 (BQI KNOWN CVD-MULT CPTS taxonomy).

EKG

Procedures (ICD Codes): V Procedure 89.51-89.53 [BQI EKG PROCEDURES taxonomy]

Best Practice Prompt Text

No EKG has been documented in past year. EKG is due for this patient.

Site Configurable? No.

B.40 CVD Known: No Statin

Description Field Text

Default Status: On

Denominator: Patients with active CVD Known tag (iCare) with no current prescriptions or contraindications for Statin medications.

Definition (Frequency): As needed when no current prescription.

Logic Detail

CVD Known tag (Proposed or Accepted): The patient is categorized in iCare with Known CVD if any of the following criteria are met:

- One ever of primary diagnosis POV for specific cerebrovascular or peripheral vascular disease diagnoses or procedures for CABG, PCI/PTCA, endarterectomy or carotid stent for ambulatory or hospitalization visits.
  - Defined as ICD 431.*, 433.*1, 434.*1, 435.3, 440.3*, 557.1 (BQI KNOWN CVD-1 DXS taxonomy)for primary diagnosis only;
  - ICD Procedures 36.1*, 36.2 (BGP CABG PROCS taxonomy);
  - CPT 33510-33519; 33521-33523; 33533-33536; 33572; 35600; S2205-S2209 (BGP CABG CPTS taxonomy);
  - ICD V45.81-V45.82 (BGP CMS PCI-PTCA DXS taxonomy);
  - ICD Procedures 36.01, 36.02, 36.05, 36.06, 36.09 (BGP CMS PCI-PTCA PROCEDURES taxonomy);
  - CPT 33140, 92980-92982, 92984, 92995, 92996 (BGP CMS PCI PTCA CPTS taxonomy);
  - ICD Procedures 38.10; 38.12-38.19; 39.50; 39.8*; 39.90 (BQI KNOWN CVD-1 PROCEDURES);
  - CPT 37205-37208; 0075T; 0076T (BQI KNOWN CVD-1 CPTS); *or*

- Two primary diagnosis POVs ever for ambulatory or hospitalization visits (not on the same date) of AMI (one instance can be an Active Problem List) at least 90 days apart but no more than 2 years between first (most recent) and last diagnosis.
  - AMI defined as ICD 410.*0; 410.*1 (BGP AMI DXS (HEDIS) taxonomy); *or*
- Three different POVs of IHD on same day for ambulatory or hospitalization visit (one POV must be a primary diagnosis; one instance can be an Active Problem List).
  - Defined as ICD 411.*, 413.*, 414.* (BQI IHD DXS taxonomy); *or*
- Three primary diagnosis POV for any IHD or other specific cerebrovascular or peripheral vascular disease diagnoses or procedures for ambulatory or hospitalization visits at least 90 days apart but no more than 5 years between first and last diagnosis (one instance can be an Active Problem List).
  - Defined as ICD 411.*, 413.*, 414.* (BQI IHD DXS taxonomy);
  - ICD 430.*; 432.*; 433.*; 434.*; 435.*; 436.*; 437.*; 440.*; 441.* (BQI KNOWN CVD-MULT DXS taxonomy);
  - ICD Procedures 38.34, 38.44, 38.64, 39.71 (BQI KNOWN CVD-MULT PROCEDURES taxonomy);
  - CPT 0001T, 0002T, 0033T, 0034T, 0035T, 0036T, 0037T, 33877, 34800, 34802, 34804, 34830, 34831, 34832 (BQI KNOWN CVD-MULT CPTS taxonomy)

Statin Medications

- Site defined Medications: V Medications in BGP HEDIS STATIN MEDS taxonomy
- NDC (National Drug Codes): V Medications as predefined in BGP HEDIS STATIN NDC taxonomy
- Statin Contraindications: Defined in RPMS Clinical Reporting System logic document.

Best Practice Prompt Text

No Statin prescribed: Patient is not documented as currently on a Statin medication. Consider prescribing a Statin medication or another lipid lowering agent, if not contraindicated.

Site Configurable? No.

B.41 CVD Known: Tobacco Use Intervention

Description Field Text

Default Status: On

Denominator: Patients with active CVD Known tag (iCare) who are documented tobacco users (smoker or smokeless) with no documented tobacco intervention after most recent tobacco use diagnosis.

Definition (Frequency): As needed when no tobacco intervention is documented.

Logic Detail

CVD Known tag (Proposed or Accepted): The patient is categorized in iCare with Known CVD if any of the following criteria are met:

- One ever of primary diagnosis POV for specific cerebrovascular or peripheral vascular disease diagnoses or procedures for CABG, PCI/PTCA, endarterectomy or carotid stent for ambulatory or hospitalization visits.
  - Defined as ICD 431.*, 433.*1, 434.*1, 435.3, 440.3*, 557.1 (BQI KNOWN CVD-1 DXS taxonomy)for primary diagnosis only;
  - ICD Procedures 36.1*, 36.2 (BGP CABG PROCS taxonomy);
  - CPT 33510-33519; 33521-33523; 33533-33536; 33572; 35600; S2205-S2209 (BGP CABG CPTS taxonomy);
  - ICD V45.81-V45.82 (BGP CMS PCI-PTCA DXS taxonomy);
  - ICD Procedures 36.01, 36.02, 36.05, 36.06, 36.09 (BGP CMS PCI-PTCA PROCEDURES taxonomy);
  - CPT 33140, 92980-92982, 92984, 92995, 92996 (BGP CMS PCI PTCA CPTS taxonomy);
  - ICD Procedures 38.10; 38.12-38.19; 39.50; 39.8*; 39.90 (BQI KNOWN CVD-1 PROCEDURES);
  - CPT 37205-37208; 0075T; 0076T (BQI KNOWN CVD-1 CPTS); *or*
- Two primary diagnosis POVs ever for ambulatory or hospitalization visits (not on the same date) of AMI (one instance can be an Active Problem List) at least 90 days apart but no more than two years between first (most recent) and last diagnosis.
  - AMI defined as ICD 410.*0; 410.*1 (BGP AMI DXS (HEDIS) taxonomy); *or*
- Three different POVs of IHD on same day for ambulatory or hospitalization visit (one POV must be a primary diagnosis; one instance can be an Active Problem List).
  - Defined as ICD 411.*, 413.*, 414.* (BQI IHD DXS taxonomy); *or*
- Three primary diagnosis POV for any IHD or other specific cerebrovascular or peripheral vascular disease diagnoses or procedures for ambulatory or hospitalization visits at least 90 days apart but no more than five years between first and last diagnosis (one instance can be an Active Problem List).
  - Defined as ICD 411.*, 413.*, 414.* (BQI IHD DXS taxonomy);

- ICD 430.*; 432.*; 433.*; 434.*; 435.*; 436.*; 437.*; 440.*; 441.* (BQI KNOWN CVD-MULT DXS taxonomy);
- ICD Procedures 38.34, 38.44, 38.64, 39.71 (BQI KNOWN CVD-MULT PROCEDURES taxonomy);
- CPT 0001T, 0002T, 0033T, 0034T, 0035T, 0036T, 0037T, 33877, 34800, 34802, 34804, 34830, 34831, 34832 (BQI KNOWN CVD-MULT CPTS taxonomy).

Tobacco Use

- Health Factors: most recent V Health Factor TBD BGP TOBACCO USER HLTH FACTORS taxonomy
- Diagnoses (ICD Codes): V POV or Problem List 305.1; 305.1* (old codes); 649.00-649.04; V15.82 [BGP GPRA SMOKING DXS taxonomy]
- V Dental: ADA 1320
- Procedures (CPT Codes): V CPT 1034F, 1035F (BGP TOBACCO USER CPTS taxonomy]

Tobacco Intervention or Cessation:

- Procedures (CPT Codes): V CPT G0375, G0376, 4000F, 4001F [BGP TOBACCO INTERVENTION CPTS taxonomy]
- Clinic: Visit Clinic Code 94 (Tobacco Cessation Clinic)
- Patient Education Codes: V Patient Ed Codes containing “TO-,” “-TO,” “-SHS,” 305.1, 649.00-649.04
- Site defined Medications: V Medications in BGP CMS SMOKING CESSATION MEDS taxonomy or med name containing “Nicotine Patch,” “Nicotine Polacrilex,” “Nicotine Inhaler,” or “Nicotine Nasal Spray”
- NDC (National Drug Codes)): V Medications as predefined in BGP CMS SMOKING CESSATION NDC taxonomy
- V Dental: ADA 1320

Best Practice Prompt Text

Tobacco Cessation: Patient is documented as a current Tobacco User. Consider tobacco cessation intervention.

Site Configurable? No.

B.42 CVD Significant Risk: HDL Not at Goal

Description Field Text

Default Status: On

Denominator: Patients with active CVD At Significant Risk (ASR) tag (iCare) with most recent HDL within past five years NOT at goal, defined as equal to or greater than 40 for males or equal to or greater than 45 for females.

Definition (Frequency): As needed when recent HDL not at goal.

Logic Detail

CVD ASR tag (Proposed or Accepted). If patient is not categorized with either Known CVD or At Highest Risk and meets either of the following criteria:

- Greater than (>) age 18 and at least two CVD Risk Factors; **or**
- Male equal to or greater than age (=>) 45 *or* Female equal to or greater than age (=>) 55; and at least 1 CVD Risk Factor.

CVD Risk Factor defined as any one of the following:

- Current Smoker: the patient has at least two primary or secondary POVs ever for ambulatory or hospitalization visits (not on the same date) or one instance on the Active Problem List or most recent tobacco Health Factor or CPT.
  - Smoking defined as ICD 305.1; 305.10-305.12 (old codes), or 649.00-649.04 (BGP SMOKER ONLY DXS) or health factors Current Smoker, Current Smoker & Smokeless, Cessation Smoker, Cessation Smoker and Smokeless (BGP SMOKING HLTH FACTORS taxonomy);
  - CPT 99406, 99407, G0375 (old code), G0376 (old code), 1034F (BGP SMOKER CPTS).
- Prediabetes Metabolic Syndrome: the patient has at least two primary or secondary diagnosis POVs ever for ambulatory or hospitalization visits (not on the same date) or one instance on the Active Problem List.
  - Defined as ICD 277.7 (BGP PRE DM MET SYN DX taxonomy).
- Hypertension: the patient has at least three primary or secondary diagnosis POVs for ambulatory or hospitalization visits separated by 90 days or one instance on the Active problem list.
  - Defined as ICD 401.0-401.9 (BGP HYPERTENSION DXS taxonomy).
- Obese: The adult patient's most recent BMI is equal to or greater than (=>) 30.
- High Blood Pressure: Two of last three non-ER blood pressures are Systolic equal to or greater than (=>) 140 or Diastolic equal to or greater than (=>) 90.
- Most recent HDL lab test is less than (<) 40 for men or less than (<) 45 for women. HDL defined by the site in DM AUDIT HDL TAX Taxonomy or pre-defined LOINC codes (BGP HDL LOINC CODES).

Evidence of High Cholesterol defined as any one of the following:

- Prescription for Statin medication in the past year defined by the site in the DM AUDIT STAIN DRUGS taxonomy or predefined NDC or class codes (BQI STATIN MEDS CLASS or BQI STATIN NDC taxonomies).
- Hyperlipidemia: At least two primary or secondary POVs ever for ambulatory or hospitalization visits (not on the same date) or one instance on the Active Problem List. Defined as ICD 272.0-272.9 (BQI HYPERLIPIDEMIA DXS taxonomy).
- LDL lab test value equal to or greater than (=>) 160 in past five years. Test is defined by the site in DM AUDIT LDL CHOLESTEROL TAX taxonomy or pre-defined LOINC Codes (BGP LDL LOINC CODES taxonomy).
- Total cholesterol value equal to or greater than (=>) 240 in past 5 years. Test is defined by the site in DM AUDIT CHOLESTEROL TAX taxonomy or pre-defined LOINC Codes (BGP TOTAL CHOLESTEROL LOINC taxonomy).
- Non HDL equal to or greater than (=>) 190 in past 5 years, defined as value of Total Cholesterol minus value of HDL, both results documented on the same date.

Evidence of Nephropathy defined as any one of the following:

- Patients with at least two instances (primary diagnosis POV, Procedure or CPT for ambulatory or hospitalization visits) or one instance on Active Problem List in past five years.
  - Defined as ICD 250.40-250.43; 403.0-405.01; 405.11; 405.91; 581.81; 582.9; 583.81; 584.5-586.; 588.0-588.9; 753.0-753.19; 791.0; V42.0; V45.1; V56.0-V56.8 (BGP NEPHROPATHY DXS taxonomy); or
  - ICD Procedures 38.95; 39.27; 39.42-39.43; 39.53; 39.93-39.95; 54.98; 55.4-55.69 (BGP NEPHROPATHY PROCEDURES taxonomy); or
  - CPTs 3066F; 36145; 36800-36815; 36818-36821; 36831-36833; 50300; 50320; 50340; 50360; 50365; 50370-50380; 90920-90921; 90924-90937; 90939-90940; 90945-90947; 90989; 90993; 90997; 90999; 99512; G0257; G0314-G0319; G0322-G0323; G0326-G0327; S9339 (BGP NEPHROPATHY CPTS taxonomy)
- Two Creatinine test results equal to or greater than (=>) 2.0 over past year, separated by at least 90 days. Creatinine test defined by the site in DM AUDIT CREATININE TAX taxonomy or pre-defined LOINC Codes (BGP CREATININE LOINC CODES).
- Two Estimated GFR values less than or equal to (<=) 30 over past year, separated by at least 90 days. Estimated GFR test defined by the site in BGP GPRA ESTIMATED GFR TAX taxonomy or by LOINC code 33914-3 (BGP ESTIMATED GFR LOINC taxonomy).

HDL Test

- Site defined Lab Tests: V Lab site defined tests in DM AUDIT HDL TAX taxonomy
- LOINC Codes: V Lab as predefined in BGP HDL LOINC CODES taxonomy

Note	CPT Codes will not be used to identify this test because a result value is required.

Best Practice Prompt Text

HDL Goal: On [date of test], patient's HDL was [xx]. Patient not at HDL goal [xx]. Consider intensified therapy.

Site Configurable? No.

B.43 CVD Significant Risk: High BP

Description Field Text

Default Status: On

Denominator: Patients with active CVD ASR (CVD ASR) tag (iCare) with two of last three non-ER blood pressures in past two years are Systolic greater than 140 or Diastolic greater than 90.

Definition (Frequency): As needed when blood pressure is elevated.

LOGIC DETAIL

CVD ASR tag (Proposed or Accepted). If patient is not categorized with either Known CVD or AHR and meets either of the following criteria:

- Greater than (>) age 18 and at least 2 CVD Risk Factors; **or**
- Male equal to or greater than age (=>) 45 *or* Female equal to or greater than age (=>) 55; and at least one CVD Risk Factor.

CVD Risk Factor defined as any one of the following:

- Current Smoker: The patient has at least two primary or secondary POVs ever for ambulatory or hospitalization visits (not on the same date) or one instance on the Active Problem List or most recent tobacco Health Factor or CPT.
  - Smoking defined as ICD 305.1; 305.10-305.12 (old codes), or 649.00-649.04 (BGP SMOKER ONLY DXS) or health factors Current Smoker, Current Smoker & Smokeless, Cessation Smoker, Cessation Smoker and Smokeless (BGP SMOKING HLTH FACTORS taxonomy);
  - CPT 99406, 99407, G0375 (old code), G0376 (old code), 1034F (BGP SMOKER CPTS).

- Prediabetes Metabolic Syndrome: the patient has at least two primary or secondary diagnosis POVs ever for ambulatory or hospitalization visits (not on the same date) or on one instance on the Active Problem List.
  - Defined as ICD 277.7 (BGP PRE DM MET SYN DX taxonomy).
- Hypertension: The patient has at least three primary or secondary diagnosis POVs for ambulatory or hospitalization visits separated by 90 days or one instance on the Active problem list.
  - Defined as ICD 401.0-401.9 (BGP HYPERTENSION DXS taxonomy).
- Obese: The adult patient's most recent BMI is equal to or greater than (=>) 30.
- High Blood Pressure: two of last three non-ER blood pressures are Systolic equal to or greater than (=>) 140 or Diastolic equal to or greater than (=>) 90.
- Most recent HDL laboratory test is less than (<) 40 for men or less than (<) 45 for women. HDL defined by the site in DM AUDIT HDL TAX Taxonomy or pre-defined LOINC Codes (BGP HDL LOINC CODES).

Evidence of High Cholesterol defined as any one of the following:

- Prescription for Statin medication in the past year defined by the site in the DM AUDIT STAIN DRUGS taxonomy or pre-defined NDC or class codes (BQI STATIN MEDS CLASS or BQI STATIN NDC taxonomies).
- Hyperlipidemia: At least two primary or secondary POVs ever for ambulatory or hospitalization visits (not on the same date) or one instance on the Active Problem List. Defined as ICD 272.0-272.9 (BQI HYPERLIPIDEMIA DXS taxonomy).
- LDL lab test value equal to or greater than (=>) 160 in past 5 years. Test is defined by the site in DM AUDIT LDL CHOLESTEROL TAX taxonomy or pre-defined LOINC Codes (BGP LDL LOINC CODES taxonomy).
- Total cholesterol value equal to or greater than (=>) 240 in past 5 years. Test is defined by the site in DM AUDIT CHOLESTEROL TAX taxonomy or pre-defined LOINC Codes (BGP TOTAL CHOLESTEROL LOINC taxonomy).
- Non HDL equal to or greater than (=>) 190 in past five years, defined as value of Total Cholesterol minus value of HDL, both results documented on the same date.

Evidence of Nephropathy defined as any one of the following:

- Patients with at least two instances (primary diagnosis POV, Procedure or CPT for ambulatory or hospitalization visits) or one instance on Active Problem List in past five years.
  - Defined as ICD 250.40-250.43; 403.0-405.01; 405.11; 405.91; 581.81; 582.9; 583.81; 584.5-586.; 588.0-588.9; 753.0-753.19; 791.0; V42.0; V45.1; V56.0-V56.8 (BGP NEPHROPATHY DXS taxonomy); or

  - ICD Procedures 38.95; 39.27; 39.42-39.43; 39.53; 39.93-39.95; 54.98; 55.4-55.69 (BGP NEPHROPATHY PROCEDURES taxonomy); or
  - CPTs 3066F; 36145; 36800-36815; 36818-36821; 36831-36833; 50300; 50320; 50340; 50360; 50365; 50370-50380; 90920-90921; 90924-90937; 90939-90940; 90945-90947; 90989; 90993; 90997; 90999; 99512; G0257; G0314-G0319; G0322-G0323; G0326-G0327; S9339 (BGP NEPHROPATHY CPTS taxonomy).
- Two Creatinine test results equal to or greater than (=>) 2.0 over past year, separated by at least 90 days. Creatinine test defined by the site in DM AUDIT CREATININE TAX taxonomy or pre-defined LOINC Codes (BGP CREATININE LOINC CODES).
- Two estimated GFR values less than or equal to (<=) 30 over past year, separated by at least 90 days. Estimated GFR test defined by the site in BGP GPRA ESTIMATED GFR TAX taxonomy or by LOINC code 33914-3 (BGP ESTIMATED GFR LOINC taxonomy).

Best Practice Prompt Text

High BP: This patient's recent documented BP is greater than (>) or equal to 140/90. Consider intensified medical therapy.

Site Configurable? No.

B.44 CVD Significant Risk: High LDL

Description Field Text

Default Status: On

Denominator: Patients with active CVD ASR tag (iCare) with most recent LDL test result within the past year is greater than 160.

Definition (Frequency): As needed when recent LDL result is higher than 160.

Logic Detail

CVD ASR tag (Proposed or Accepted). If patient is not categorized with either Known CVD or AHR and meets either of the following criteria:

- Greater than (>) age 18 and at least 2 CVD Risk Factors; *or*
- Male equal to or greater than age (=>) 45 *or* Female equal to or greater than age (=>) 55; and at least 1 CVD Risk Factor.

CVD Risk Factor defined as any one of the following:

- Current Smoker: The patient has at least two primary or secondary POVs ever for ambulatory or hospitalization visits (not on the same date) or one instance on the Active Problem List or most recent tobacco Health Factor or CPT.

  - Smoking defined as ICD 305.1; 305.10-305.12 (old codes), or 649.00-649.04 (BGP SMOKER ONLY DXS) or health factors Current Smoker, Current Smoker & Smokeless, Cessation Smoker, Cessation Smoker and Smokeless (BGP SMOKING HLTH FACTORS taxonomy);
  - CPT 99406, 99407, G0375 (old code), G0376 (old code), 1034F (BGP SMOKER CPTS).
- Prediabetes Metabolic Syndrome: the patient has at least two primary or secondary diagnosis POVs ever for ambulatory or hospitalization visits (not on the same date) or on one instance on the Active Problem List.
  - Defined as ICD 277.7 (BGP PRE DM MET SYN DX taxonomy).
- Hypertension: The patient has at least 3 primary or secondary diagnosis POVs for ambulatory or hospitalization visits separated by 90 days or one instance on the Active problem list.
  - Defined as ICD 401.0-401.9 (BGP HYPERTENSION DXS taxonomy).
- Obese: The adult patient's most recent BMI is equal to or greater than (=>) 30.
- High Blood Pressure: Two of last three non-ER blood pressures are Systolic equal to or greater than (=>) 140 or Diastolic equal to or greater than (=>) 90.
- Most recent HDL lab test is less than (<) 40 for men or less than (<) 45 for women. HDL defined by the site in DM AUDIT HDL TAX Taxonomy or pre-defined LOINC Codes (BGP HDL LOINC CODES).

Evidence of High Cholesterol defined as any one of the following:

- Prescription for Statin medication in the past year defined by the site in the DM AUDIT STAIN DRUGS taxonomy or pre-defined NDC or class codes (BQI STATIN MEDS CLASS or BQI STATIN NDC taxonomies).
- Hyperlipidemia: At least two primary or secondary POVs ever for ambulatory or hospitalization visits (not on the same date) or one instance on the Active Problem List.
  - Defined as ICD 272.0-272.9 (BQI HYPERLIPIDEMIA DXS taxonomy).
- LDL laboratory test value equal to or greater than (=>) 160 in past five years. Test is defined by the site in DM AUDIT LDL CHOLESTEROL TAX taxonomy or predefined LOINC Codes (BGP LDL LOINC CODES taxonomy).
- Total cholesterol value equal to or greater than (=>) 240 in past 5 years. Test is defined by the site in DM AUDIT CHOLESTEROL TAX taxonomy or pre-defined LOINC Codes (BGP TOTAL CHOLESTEROL LOINC taxonomy).

- Non HDL equal to or greater than (=>) 190 in past 5 years, defined as value of Total Cholesterol minus value of HDL, both results documented on the same date.

Evidence of Nephropathy: defined as any one of the following:

- Patients with at least two instances (primary diagnosis POV, Procedure or CPT for ambulatory or hospitalization visits) or one instance on Active Problem List in past five years.
  - Defined as ICD 250.40-250.43; 403.0-405.01; 405.11; 405.91; 581.81; 582.9; 583.81; 584.5-586.; 588.0-588.9; 753.0-753.19; 791.0; V42.0; V45.1; V56.0-V56.8 (BGP NEPHROPATHY DXS taxonomy); *or*
  - ICD Procedures 38.95; 39.27; 39.42-39.43; 39.53; 39.93-39.95; 54.98; 55.4-55.69 (BGP NEPHROPATHY PROCEDURES taxonomy); *or*
  - CPTs 3066F; 36145; 36800-36815; 36818-36821; 36831-36833; 50300; 50320; 50340; 50360; 50365; 50370-50380; 90920-90921; 90924-90937; 90939-90940; 90945-90947; 90989; 90993; 90997; 90999; 99512; G0257; G0314-G0319; G0322-G0323; G0326-G0327; S9339 (BGP NEPHROPATHY CPTS taxonomy).
- Two Creatinine test results equal to or greater than (=>) 2.0 over past year, separated by at least 90 days. Creatinine test defined by the site in DM AUDIT CREATININE TAX taxonomy or pre-defined LOINC Codes (BGP CREATININE LOINC CODES).
- Two estimated GFR values less than or equal to (<=) 30 over past year, separated by at least 90 days. Estimated GFR test defined by the site in BGP GPRA ESTIMATED GFR TAX taxonomy or by LOINC code 33914-3 (BGP ESTIMATED GFR LOINC taxonomy).

LDL Test

- Site defined Lab Tests: V Lab site defined tests in DM AUDIT LDL CHOLESTEROL TAX taxonomy
- LOINC Codes: V Lab as predefined in BGP LDL LOINC CODES taxonomy

Note	CPT Codes will not be used to identify this test because a result value is required.

Best Practice Prompt Text

High LDL: On [date of test], patient's LDL was [xx]. Intensify therapy and reevaluate in two months.

Site Configurable? No.

B.45 CVD Significant Risk: Low LDL

Description Field Text

Default Status: On

Denominator: Patients with active CVD At Significant Risk (ASR) tag (iCare) with current prescription or contraindicated for Statin medications *and* with most recent LDL test result in the past year equal to or less than (=<) 160 *and* most recent HDL result in the past year less than (<) 40.

Definition (Frequency): As needed.

Logic Detail

CVD ASR tag (Proposed or Accepted). If patient is not categorized with either Known CVD or At Highest Risk and meets either of the following criteria:

- Greater than (>) age 18 and at least 2 CVD Risk Factors; or
- Male equal to or greater than age (=>) 45 *or* female equal to or greater than age (=>) 55; and at least 1 CVD Risk Factor.

CVD Risk Factor defined as any one of the following:

- Current Smoker: The patient has at least two primary or secondary POVs ever for ambulatory or hospitalization visits (not on the same date) or one instance on the Active Problem List or most recent tobacco Health Factor or CPT.
  - Smoking defined as ICD 305.1; 305.10-305.12 (old codes), or 649.00-649.04 (BGP SMOKER ONLY DXS) or health factors Current Smoker, Current Smoker & Smokeless, Cessation Smoker, Cessation Smoker and Smokeless (BGP SMOKING HLTH FACTORS taxonomy);
  - CPT 99406, 99407, G0375 (old code), G0376 (old code), 1034F (BGP SMOKER CPTS).
- Prediabetes Metabolic Syndrome: The patient has at least two primary or secondary diagnosis POVs ever for ambulatory or hospitalization visits (not on the same date) or on one instance on the Active Problem List.
  - Defined as ICD 277.7 (BGP PRE DM MET SYN DX taxonomy).
- Hypertension: The patient has at least three primary or secondary diagnosis POVs for ambulatory or hospitalization visits separated by 90 days or one instance on the Active problem list.
  - Defined as ICD 401.0-401.9 (BGP HYPERTENSION DXS taxonomy).
- Obese: The adult patient's most recent BMI is equal to or greater than (=>) 30.
- High Blood Pressure: Two of last three non-ER blood pressures are Systolic equal to or greater than (=>) 140 or Diastolic equal to or greater than (=>) 90.

- Most recent HDL laboratory test is less than (<) 40 for men or less than (<) 45 for women. HDL defined by the site in DM AUDIT HDL TAX Taxonomy or pre-defined LOINC Codes (BGP HDL LOINC CODES).

Evidence of High Cholesterol defined as any one of the following:

- Prescription for Statin medication in the past year defined by the site in the DM AUDIT STAIN DRUGS taxonomy or pre-defined NDC or class codes (BQI STATIN MEDS CLASS or BQI STATIN NDC taxonomies).
- Hyperlipidemia: At least two primary or secondary POVs ever for ambulatory or hospitalization visits (not on the same date) or one instance on the Active Problem List.
  - Defined as ICD 272.0-272.9 (BQI HYPERLIPIDEMIA DXS taxonomy).
- LDL laboratory test value equal to or greater than (=>) 160 in past 5 years. Test is defined by the site in DM AUDIT LDL CHOLESTEROL TAX taxonomy or predefined LOINC Codes (BGP LDL LOINC CODES taxonomy).
- Total cholesterol value equal to or greater than (=>) 240 in past 5 years. Test is defined by the site in DM AUDIT CHOLESTEROL TAX taxonomy or predefined LOINC Codes (BGP TOTAL CHOLESTEROL LOINC taxonomy).
- Non HDL equal to or greater than (=>) 190 in past 5 years, defined as value of Total Cholesterol minus value of HDL, both results documented on the same date.

Evidence of Nephropathy: defined as any one of the following:

- Patients with at least two instances (primary diagnosis POV, Procedure or CPT for ambulatory or hospitalization visits) or one instance on Active Problem List in past five years.
  - Defined as ICD 250.40-250.43; 403.0-405.01; 405.11; 405.91; 581.81; 582.9; 583.81; 584.5-586.; 588.0-588.9; 753.0-753.19; 791.0; V42.0; V45.1; V56.0-V56.8 (BGP NEPHROPATHY DXS taxonomy); *or*
  - ICD Procedures 38.95; 39.27; 39.42-39.43; 39.53; 39.93-39.95; 54.98; 55.4-55.69 (BGP NEPHROPATHY PROCEDURES taxonomy); *or*
  - CPTs 3066F; 36145; 36800-36815; 36818-36821; 36831-36833; 50300; 50320; 50340; 50360; 50365; 50370-50380; 90920-90921; 90924-90937; 90939-90940; 90945-90947; 90989; 90993; 90997; 90999; 99512; G0257; G0314-G0319; G0322-G0323; G0326-G0327; S9339 (BGP NEPHROPATHY CPTS taxonomy)

- Two Creatinine test results equal to or greater than (=>) 2.0 over past year, separated by at least 90 days. Creatinine test defined by the site in DM AUDIT CREATININE TAX taxonomy or pre-defined LOINC Codes (BGP CREATININE LOINC CODES).
- Two estimated GFR values less than or equal to (<=) 30 over past year, separated by at least 90 days. Estimated GFR test defined by the site in BGP GPRA ESTIMATED GFR TAX taxonomy or by LOINC code 33914-3 (BGP ESTIMATED GFR LOINC taxonomy).

LDL Test

- Site defined Lab Tests: V Lab site defined tests in DM AUDIT LDL CHOLESTEROL TAX taxonomy
- LOINC Codes: V Lab as predefined in BGP LDL LOINC CODES taxonomy

Note: CPT Codes will not be used to identify this test because a result value is required.

HDL Test

- Site defined Lab Tests: V Lab site defined tests in DM AUDIT HDL TAX taxonomy
- LOINC Codes: V Lab as predefined in BGP HDL LOINC CODES taxonomy

Note: CPT Codes will not be used to identify this test because a result value is required.

Statin Medications

- Site defined Medications: V Medications in BGP HEDIS STATIN MEDS taxonomy
- NDC (National Drug Codes): V Medications as predefined in BGP HEDIS STATIN NDC taxonomy
- Statin Contraindications: Defined in RPMS Clinical Reporting System logic document.

Best Practice Prompt Text

Low HDL: On [date of test], patient's HDL was [xx]. Consider therapeutic lifestyle changes and medical intervention if needed.

Site Configurable? No.

B.46 CVD Significant Risk: Missing Risk Factors

Description Field Text

Default Status: On

Denominator: Patients with active CVD ASR tag (iCare) who are not documented in RPMS for any or all of the following CVD risk factors:

- Tobacco Use Screen in the past year; and/or
- Total Cholesterol test in past 5 years; and/or
- HDL with result in past 5 years; and/or
- LDL with result in past 5 years; and/or
- Blood Pressure in the past year.

Definition (Frequency): As needed when any risk factors are missing.

Logic Detail

CVD ASR tag (Proposed or Accepted). If patient is not categorized with either Known CVD or AHR and meets either of the following criteria:

- Greater than (>) age 18 and at least 2 CVD Risk Factors; *or*
- Male equal to or greater than age (=>) 45 *or* Female equal to or greater than age (=>) 55; and at least 1 CVD Risk Factor.

CVD Risk Factor defined as any one of the following:

- Current Smoker: The patient has at least two primary or secondary POVs ever for ambulatory or hospitalization visits (not on the same date) or one instance on the Active Problem List or most recent tobacco Health Factor; or
  - CPT. Smoking defined as ICD 305.1; 305.10-305.12 (old codes), or 649.00-649.04 (BGP SMOKER ONLY DXS) or health factors Current Smoker, Current Smoker & Smokeless, Cessation Smoker, Cessation Smoker and Smokeless (BGP SMOKING HLTH FACTORS taxonomy); CPT 99406, 99407, G0375 (old code), G0376 (old code), 1034F (BGP SMOKER CPTS).
- Prediabetes Metabolic Syndrome: The patient has at least two primary or secondary diagnosis POVs ever for ambulatory or hospitalization visits (not on the same date) or on one instance on the Active Problem List.
  - Defined as ICD 277.7 (BGP PRE DM MET SYN DX taxonomy).
- Hypertension: the patient has at least 3 primary or secondary diagnosis POVs for ambulatory or hospitalization visits separated by 90 days or one instance on the Active problem list.

  - Defined as ICD 401.0-401.9 (BGP HYPERTENSION DXS taxonomy)
- Obese: The adult patient's most recent BMI is equal to or greater than (=>) 30.
- High Blood Pressure: Two of last three non-ER blood pressures are Systolic equal to or greater than (=>) 140 or Diastolic equal to or greater than (=>) 90.
- Most recent HDL lab test is less than (<) 40 for men or less than (<) 45 for women. HDL defined by the site in DM AUDIT HDL TAX Taxonomy or pre-defined LOINC Codes (BGP HDL LOINC CODES)

Evidence of High Cholesterol defined as any one of the following:

- Prescription for Statin medication in the past year, defined by the site in the DM AUDIT STAIN DRUGS taxonomy or predefined NDC or class codes (BQI STATIN MEDS CLASS or BQI STATIN NDC taxonomies)
- Hyperlipidemia: At least two primary or secondary POVs ever for ambulatory or hospitalization visits (not on the same date) or one instance on the Active Problem List. Defined as ICD 272.0-272.9 (BQI HYPERLIPIDEMIA DXS taxonomy)
- LDL lab test value equal to or greater than (=>) 160 in past 5 years. Test is defined by the site in DM AUDIT LDL CHOLESTEROL TAX taxonomy or pre-defined LOINC Codes (BGP LDL LOINC CODES taxonomy)
- Total cholesterol value equal to or greater than (=>) 240 in past 5 years. Test is defined by the site in DM AUDIT CHOLESTEROL TAX taxonomy or pre-defined LOINC Codes (BGP TOTAL CHOLESTEROL LOINC taxonomy)
- Non HDL equal to or greater than (=>) 190 in past 5 years, defined as value of Total Cholesterol minus value of HDL, both results documented on the same date

Evidence of Nephropathy defined as any one of the following:

- Patients with at least two instances (primary diagnosis POV, Procedure or CPT for ambulatory or hospitalization visits) or one instance on Active Problem List in past five years
  - Defined as ICD 250.40-250.43; 403.0-405.01; 405.11; 405.91; 581.81; 582.9; 583.81; 584.5-586.; 588.0-588.9; 753.0-753.19; 791.0; V42.0; V45.1; V56.0-V56.8 (BGP NEPHROPATHY DXS taxonomy); *or*
  - ICD Procedures 38.95; 39.27; 39.42-39.43; 39.53; 39.93-39.95; 54.98; 55.4-55.69 (BGP NEPHROPATHY PROCEDURES taxonomy); *or*
  - CPTs 3066F; 36145; 36800-36815; 36818-36821; 36831-36833; 50300; 50320; 50340; 50360; 50365; 50370-50380; 90920-90921; 90924-90937; 90939-90940; 90945-90947; 90989; 90993; 90997; 90999; 99512; G0257; G0314-G0319; G0322-G0323; G0326-G0327; S9339 (BGP NEPHROPATHY CPTS taxonomy)

- Two Creatinine test results equal to or greater than (=>) 2.0 over past year, separated by at least 90 days. Creatinine test defined by the site in DM AUDIT CREATININE TAX taxonomy or predefined LOINC Codes (BGP CREATININE LOINC CODES)
- Two estimated GFR values less than or equal to (<=) 30 over past year, separated by at least 90 days. Estimated GFR test defined by the site in BGP GPRA ESTIMATED GFR TAX taxonomy or by LOINC Code 33914-3 (BGP ESTIMATED GFR LOINC taxonomy)

Tobacco Use Screen

- Health Factors: most recent V Health Factor TBD BGP TOBACCO USER HLTH FACTORS taxonomy
  - Diagnoses (ICD Codes): V POV or Problem List 305.1; 305.1* (old codes); 649.00-649.04; V15.82 [BGP GPRA SMOKING DXS taxonomy]
  - V Dental: ADA 1320
  - Procedures (CPT Codes): V CPT 1034F, 1035F (BGP TOBACCO USER CPTS taxonomy]

Total Cholesterol Test

- Site defined Lab Tests: V Lab site defined tests in DM AUDIT CHOLESTEROL TAX taxonomy
- LOINC Codes: V Lab as predefined in BGP TOTAL CHOLESTEROL LOINC taxonomy

Note	CPT Codes will not be used to identify this test because a result value is required.

HDL Test

- Site-Defined Lab Tests: V Lab site defined tests in DM AUDIT HDL TAX taxonomy
- LOINC Codes: V Lab as predefined in BGP HDL LOINC CODES taxonomy

Note	CPT Codes will not be used to identify this test because a result value is required.

LDL Test

- Site-Defined Lab Tests: V Lab site defined tests in DM AUDIT LDL CHOLESTEROL TAX taxonomy
- LOINC Codes: V Lab as predefined in BGP LDL LOINC CODES taxonomy

Note	CPT Codes will not be used to identify this test because a result value is required.

Best Practice Prompt Text

Missing information regarding: CVD Risk Factors: This patient may be at risk for CVD. Currently unable to calculate level of risk for this patient and assist in treatment recommendations because the following data is missing [list specifics].

Site Configurable? No.

B.47 CVD Significant Risk: No ASA/Antiplatelet

Description Field Text

Default Status: On

Denominator: Patients with active CVD ASR tag (iCare) with no current prescriptions or contraindications for Aspirin/ASA, Warfarin or other Anti Platelet medications.

Definition (Frequency): As needed when no current prescription.

Logic Detail

CVD ASR tag (Proposed or Accepted). If patient is not categorized with either Known CVD or AHR and meets either of the following criteria:

- Greater than (>) age 18 and at least 2 CVD Risk Factors; *or*
- Male equal to or greater than age (=>) 45 *or* female equal to or greater than age (=>) 55; and at least 1 CVD Risk Factor.

CVD Risk Factor defined as any one of the following:

- Current Smoker: The patient has at least two primary or secondary POVs ever for ambulatory or hospitalization visits (not on the same date) or one instance on the Active Problem List or most recent tobacco Health Factor or CPT.
  - Smoking defined as ICD 305.1; 305.10-305.12 (old codes), or 649.00-649.04 (BGP SMOKER ONLY DXS) or health factors Current Smoker, Current Smoker & Smokeless, Cessation Smoker, Cessation Smoker and Smokeless (BGP SMOKING HLTH FACTORS taxonomy); CPT 99406, 99407, G0375 (old code), G0376 (old code), 1034F (BGP SMOKER CPTS).
- Prediabetes Metabolic Syndrome: The patient has at least two primary or secondary diagnosis POVs ever for ambulatory or hospitalization visits (not on the same date) or on one instance on the Active Problem List

  - Defined as ICD 277.7 (BGP PRE DM MET SYN DX taxonomy)
- Hypertension: The patient has at least three primary or secondary diagnosis POVs for ambulatory or hospitalization visits separated by 90 days or one instance on the Active problem list
  - Defined as ICD 401.0-401.9 (BGP HYPERTENSION DXS taxonomy).
- Obese: The adult patient's most recent BMI is equal to or greater than (=>) 30.
- High Blood Pressure: Two of last three non-ER blood pressures are Systolic equal to or greater than (=>) 140 or Diastolic equal to or greater than (=>) 90.
- Most recent HDL lab test is less than (<) 40 for men or less than (<) 45 for women. HDL defined by the site in DM AUDIT HDL TAX Taxonomy or pre-defined LOINC Codes (BGP HDL LOINC CODES).

Evidence of High Cholesterol defined as any one of the following:

- Prescription for Statin medication in the past year defined by the site in the DM AUDIT STAIN DRUGS taxonomy or pre-defined NDC or class codes (BQI STATIN MEDS CLASS or BQI STATIN NDC taxonomies).
- Hyperlipidemia: At least two primary or secondary POVs ever for ambulatory or hospitalization visits (not on the same date) or one instance on the Active Problem List.
  - Defined as ICD 272.0-272.9 (BQI HYPERLIPIDEMIA DXS taxonomy).
- LDL lab test value equal to or greater than (=>) 160 in past 5 years. Test is defined by the site in DM AUDIT LDL CHOLESTEROL TAX taxonomy or predefined LOINC Codes (BGP LDL LOINC CODES taxonomy).
- Total cholesterol value equal to or greater than (=>) 240 in 5 five years. Test is defined by the site in DM AUDIT CHOLESTEROL TAX taxonomy or pre-defined LOINC Codes (BGP TOTAL CHOLESTEROL LOINC taxonomy).
- Non HDL equal to or greater than (=>) 190 in past 5 years, defined as value of Total Cholesterol minus value of HDL, both results documented on the same date.

Evidence of Nephropathy defined as any one of the following:

- Patients with at least two instances (primary diagnosis POV, Procedure or CPT for ambulatory or hospitalization visits) or one instance on Active Problem List in past five years.
  - Defined as ICD 250.40-250.43; 403.0-405.01; 405.11; 405.91; 581.81; 582.9; 583.81; 584.5-586.; 588.0-588.9; 753.0-753.19; 791.0; V42.0; V45.1; V56.0-V56.8 (BGP NEPHROPATHY DXS taxonomy) or
  - ICD Procedures 38.95; 39.27; 39.42-39.43; 39.53; 39.93-39.95; 54.98; 55.4-55.69 (BGP NEPHROPATHY PROCEDURES taxonomy) or

  - CPTs 3066F; 36145; 36800-36815; 36818-36821; 36831-36833; 50300; 50320; 50340; 50360; 50365; 50370-50380; 90920-90921; 90924-90937; 90939-90940; 90945-90947; 90989; 90993; 90997; 90999; 99512; G0257; G0314-G0319; G0322-G0323; G0326-G0327; S9339 (BGP NEPHROPATHY CPTS taxonomy).
- Two Creatinine test results equal to or greater than (=>) 2.0 over past year, separated by at least 90 days. Creatinine test defined by the site in DM AUDIT CREATININE TAX taxonomy or predefined LOINC Codes (BGP CREATININE LOINC CODES).
- Two estimated GFR values less than or equal to (<=) 30 over past year, separated by at least 90 days. Estimated GFR test defined by the site in BGP GPRA ESTIMATED GFR TAX taxonomy or by LOINC Code 33914-3 (BGP ESTIMATED GFR LOINC taxonomy).

Aspirin/ASA Medications

- Site defined Medications: V Medications in DM AUDIT ASPIRIN DRUGS taxonomy
- NDC (National Drug Codes): V Medications as predefined in BAT ASTHMA INHLD STEROIDS NDC taxonomy

Anti Platelet Medications

- Site defined Medications: V Medications in BGP ANTIPLATELET DRUGS taxonomy
- VA Drug Class: V Medications as predefined in BGP CMS ANTI-PLATELET CLASS NDC taxonomy

Warfarin

- Site defined Medications: V Medications in BGP CMS WARFARIN MEDS taxonomy
- NDC (National Drug Codes): V Medications as predefined in BAT ASTHMA INHLD STEROIDS NDC taxonomy
- Medication Contraindications: Defined in RPMS Clinical Reporting System logic document.

Best Practice Prompt Text

- Treatment Recommendation: Patient has two or more risk factors for cardiovascular disease and has no documentation of ASA, Warfarin medications or any other anti-platelet therapy. Consider aspirin therapy, if not contraindicated.

Site Configurable? No.

B.48 CVD Significant Risk: No Exercise Education

Description Field Text

Default Status: On

Denominator: Patients with active CVD ASR tag (iCare) with no documented exercise education in the past year.

Definition (Frequency): As needed when no exercise education is documented.

Logic Detail

CVD ASR tag (Proposed or Accepted). If patient is not categorized with either Known CVD or AHR and meets either of the following criteria:

- Greater than (>) age 18 and at least 2 CVD Risk Factors; or
- Male equal to or greater than age (=>) 45 *or* female equal to or greater than age (=>) 55; and at least 1 CVD Risk Factor.

CVD Risk Factor defined as any one of the following:

- Current Smoker: The patient has at least two primary or secondary POVs ever for ambulatory or hospitalization visits (not on the same date) or one instance on the Active Problem List or most recent tobacco Health Factor or CPT.
  - Smoking defined as ICD 305.1; 305.10-305.12 (old codes), or 649.00-649.04 (BGP SMOKER ONLY DXS) or health factors Current Smoker, Current Smoker & Smokeless, Cessation Smoker, Cessation Smoker and Smokeless (BGP SMOKING HLTH FACTORS taxonomy); CPT 99406, 99407, G0375 (old code), G0376 (old code), 1034F (BGP SMOKER CPTS).
- Prediabetes Metabolic Syndrome: The patient has at least two primary or secondary diagnosis POVs ever for ambulatory or hospitalization visits (not on the same date) or on one instance on the Active Problem List.
  - Defined as ICD 277.7 (BGP PRE DM MET SYN DX taxonomy).
- Hypertension: the patient has at least 3 primary or secondary diagnosis POVs for ambulatory or hospitalization visits separated by 90 days or one instance on the Active problem list.
  - Defined as ICD 401.0-401.9 (BGP HYPERTENSION DXS taxonomy).
- Obese: The adult patient's most recent BMI is equal to or greater than (=>) 30.
- High Blood Pressure: Two of last three non-ER blood pressures are Systolic equal to or greater than (=>) 140 or Diastolic equal to or greater than (=>) 90.

- Most recent HDL laboratory test is less than (<) 40 for men or less than (<) 45 for women. HDL defined by the site in DM AUDIT HDL TAX Taxonomy or pre-defined LOINC Codes (BGP HDL LOINC CODES).

Evidence of High Cholesterol defined as any one of the following:

- Prescription for Statin medication in the past year defined by the site in the DM AUDIT STAIN DRUGS taxonomy or predefined NDC or class codes (BQI STATIN MEDS CLASS or BQI STATIN NDC taxonomies).
- Hyperlipidemia: At least two primary or secondary POVs ever for ambulatory or hospitalization visits (not on the same date) or one instance on the Active Problem List. Defined as ICD 272.0-272.9 (BQI HYPERLIPIDEMIA DXS taxonomy).
- LDL lab test value equal to or greater than (=>) 160 in past 5 years. Test is defined by the site in DM AUDIT LDL CHOLESTEROL TAX taxonomy or pre-defined LOINC Codes (BGP LDL LOINC CODES taxonomy).
- Total cholesterol value equal to or greater than (=>) 240 in past 5 years. Test is defined by the site in DM AUDIT CHOLESTEROL TAX taxonomy or pre-defined LOINC Codes (BGP TOTAL CHOLESTEROL LOINC taxonomy).
- Non HDL equal to or greater than (=>) 190 in past 5 years, defined as value of Total Cholesterol minus value of HDL, both results documented on the same date.

Evidence of Nephropathy defined as any one of the following:

- Patients with at least two instances (primary diagnosis POV, Procedure or CPT for ambulatory or hospitalization visits) or one instance on Active Problem List in past five years.
  - Defined as ICD 250.40-250.43; 403.0-405.01; 405.11; 405.91; 581.81; 582.9; 583.81; 584.5-586.; 588.0-588.9; 753.0-753.19; 791.0; V42.0; V45.1; V56.0-V56.8 (BGP NEPHROPATHY DXS taxonomy); *or*
  - ICD Procedures 38.95; 39.27; 39.42-39.43; 39.53; 39.93-39.95; 54.98; 55.4-55.69 (BGP NEPHROPATHY PROCEDURES taxonomy); *or*
  - CPTs 3066F; 36145; 36800-36815; 36818-36821; 36831-36833; 50300; 50320; 50340; 50360; 50365; 50370-50380; 90920-90921; 90924-90937; 90939-90940; 90945-90947; 90989; 90993; 90997; 90999; 99512; G0257; G0314-G0319; G0322-G0323; G0326-G0327; S9339 (BGP NEPHROPATHY CPTS taxonomy).
- Two Creatinine test results equal to or greater than (=>) 2.0 over past year, separated by at least 90 days. Creatinine test defined by the site in DM AUDIT CREATININE TAX taxonomy or predefined LOINC Codes (BGP CREATININE LOINC CODES).

- Two estimated GFR values less than or equal to (<=) 30 over past year, separated by at least 90 days. Estimated GFR test defined by the site in BGP GPRA ESTIMATED GFR TAX taxonomy or by LOINC Code 33914-3 (BGP ESTIMATED GFR LOINC taxonomy).

Exercise Education

Diagnoses (ICD Codes): V POV V65.41

Patient Education Codes: V Patient Ed Codes containing "EX"

Best Practice Prompt Text

No Recent Exercise Education: Discuss and document exercise education with this patient.

Site Configurable? No.

B.49 CVD Significant Risk: No Nutrition Education

Description Field Text

Default Status: On

Denominator: Patients with active CVD ASR tag (iCare) with no documented nutrition education in the past year.

Definition (Frequency): As needed when no nutrition education is documented.

Logic Detail

CVD ASR tag (Proposed or Accepted). If patient is not categorized with either Known CVD or AHR and meets either of the following criteria:

- Greater than (>) age 18 and at least 2 CVD Risk Factors; or
- Male equal to or greater than age (=>) 45 *or* Female equal to or greater than age (=>) 55; and at least 1 CVD Risk Factor.

CVD Risk Factor defined as any one of the following:

- Current Smoker: The patient has at least two primary or secondary POVs ever for ambulatory or hospitalization visits (not on the same date) or one instance on the Active Problem List or most recent tobacco Health Factor or CPT.
  - Smoking defined as ICD 305.1; 305.10-305.12 (old codes), or 649.00-649.04 (BGP SMOKER ONLY DXS) or health factors Current Smoker, Current Smoker & Smokeless, Cessation Smoker, Cessation Smoker and Smokeless (BGP SMOKING HLTH FACTORS taxonomy); CPT 99406, 99407, G0375 (old code), G0376 (old code), 1034F (BGP SMOKER CPTS).

- Prediabetes Metabolic Syndrome: The patient has at least two primary or secondary diagnosis POVs ever for ambulatory or hospitalization visits (not on the same date) or on one instance on the Active Problem List.
  - Defined as ICD 277.7 (BGP PRE DM MET SYN DX taxonomy).
- Hypertension: The patient has at least three primary or secondary diagnosis POVs for ambulatory or hospitalization visits separated by 90 days or one instance on the Active problem list.
  - Defined as ICD 401.0-401.9 (BGP HYPERTENSION DXS taxonomy).
- Obese: The adult patient's most recent BMI is equal to or greater than (=>) 30.
- High Blood Pressure: Two of last three non-ER blood pressures are Systolic equal to or greater than (=>) 140 or Diastolic equal to or greater than (=>) 90.
- Most recent HDL lab test is less than (<) 40 for men or less than (<) 45 for women. HDL defined by the site in DM AUDIT HDL TAX Taxonomy or pre-defined LOINC codes (BGP HDL LOINC CODES).

Evidence of High Cholesterol defined as any one of the following:

- Prescription for Statin medication in the past year defined by the site in the DM AUDIT STAIN DRUGS taxonomy or predefined NDC or class codes (BQI STATIN MEDS CLASS or BQI STATIN NDC taxonomies).
- Hyperlipidemia: At least two primary or secondary POVs ever for ambulatory or hospitalization visits (not on the same date) or one instance on the Active Problem List. Defined as ICD 272.0-272.9 (BQI HYPERLIPIDEMIA DXS taxonomy).
- LDL lab test value equal to or greater than (=>) 160 in past five years. Test is defined by the site in DM AUDIT LDL CHOLESTEROL TAX taxonomy or pre-defined LOINC Codes (BGP LDL LOINC CODES taxonomy).
- Total cholesterol value equal to or greater than (=>) 240 in past five years. Test is defined by the site in DM AUDIT CHOLESTEROL TAX taxonomy or predefined LOINC Codes (BGP TOTAL CHOLESTEROL LOINC taxonomy).
- Non HDL equal to or greater than (=>) 190 in past five years, defined as value of Total Cholesterol minus value of HDL, both results documented on the same date.

Evidence of Nephropathy defined as any one of the following:

- Patients with at least two instances (primary diagnosis POV, Procedure or CPT for ambulatory or hospitalization visits) or one instance on Active Problem List in past five years.

  - Defined as ICD 250.40-250.43; 403.0-405.01; 405.11; 405.91; 581.81; 582.9; 583.81; 584.5-586.; 588.0-588.9; 753.0-753.19; 791.0; V42.0; V45.1; V56.0-V56.8 (BGP NEPHROPATHY DXS taxonomy); *or*
  - ICD Procedures 38.95; 39.27; 39.42-39.43; 39.53; 39.93-39.95; 54.98; 55.4-55.69 (BGP NEPHROPATHY PROCEDURES taxonomy); *or*
  - CPTs 3066F; 36145; 36800-36815; 36818-36821; 36831-36833; 50300; 50320; 50340; 50360; 50365; 50370-50380; 90920-90921; 90924-90937; 90939-90940; 90945-90947; 90989; 90993; 90997; 90999; 99512; G0257; G0314-G0319; G0322-G0323; G0326-G0327; S9339 (BGP NEPHROPATHY CPTS taxonomy).
- Two Creatinine test results equal to or greater than (=>) 2.0 over past year, separated by at least 90 days. Creatinine test defined by the site in DM AUDIT CREATININE TAX taxonomy or predefined LOINC Codes (BGP CREATININE LOINC CODES).
- Two estimated GFR values less than or equal to (<=) 30 over past year, separated by at least 90 days. Estimated GFR test defined by the site in BGP GPRA ESTIMATED GFR TAX taxonomy or by LOINC code 33914-3 (BGP ESTIMATED GFR LOINC taxonomy).

Nutrition Education

Diagnoses (ICD Codes): V POV V65.3

Patient Education Codes: V Patient Ed Codes containing " N" or "-MNT"

Best Practice Prompt Text

No Recent Nutrition Education: Discuss and document nutrition education with this patient.

Site Configurable? No.

B.50 CVD Significant Risk: TG Not at Goal

Description Field Text

Default Status: On

Denominator: Patients with active CVD ASR tag (iCare) with most recent Triglyceride (TG) test result within the past five years is 150–499.

Definition (Frequency): As needed when recent TG not at goal.

Logic Detail

CVD At Significant Risk tag (Proposed or Accepted). If patient is not categorized with either Known CVD or AHR and meets either of the following criteria:

- Greater than (>) age 18 and at least 2 CVD Risk Factors; or
- Male equal to or greater than age (=>) 45 *or* Female equal to or greater than age (=>) 55; and at least one CVD Risk Factor.

CVD Risk Factor defined as any one of the following:

- Current Smoker: The patient has at least two primary or secondary POVs ever for ambulatory or hospitalization visits (not on the same date) or one instance on the Active Problem List or most recent tobacco Health Factor or CPT.
  - Smoking defined as ICD 305.1; 305.10-305.12 (old codes), or 649.00-649.04 (BGP SMOKER ONLY DXS) or health factors Current Smoker, Current Smoker & Smokeless, Cessation Smoker, Cessation Smoker and Smokeless (BGP SMOKING HLTH FACTORS taxonomy); CPT 99406, 99407, G0375 (old code), G0376 (old code), 1034F (BGP SMOKER CPTS).
- Prediabetes Metabolic Syndrome: The patient has at least two primary or secondary diagnosis POVs ever for ambulatory or hospitalization visits (not on the same date) or on one instance on the Active Problem List.
  - Defined as ICD 277.7 (BGP PRE DM MET SYN DX taxonomy).
- Hypertension: The patient has at least three primary or secondary diagnosis POVs for ambulatory or hospitalization visits separated by 90 days or one instance on the Active problem list.
  - Defined as ICD 401.0-401.9 (BGP HYPERTENSION DXS taxonomy).
- Obese: The adult patient's most recent BMI is equal to or greater than (=>) 30.
- High Blood Pressure: Two of last three non-ER blood pressures are Systolic equal to or greater than (=>) 140 or Diastolic equal to or greater than (=>) 90.
- Most recent HDL laboratory test is less than (<) 40 for men or less than (<) 45 for women. HDL defined by the site in DM AUDIT HDL TAX Taxonomy or pre-defined LOINC Codes (BGP HDL LOINC CODES).

Evidence of High Cholesterol defined as any one of the following:

- Prescription for Statin medication in the past year defined by the site in the DM AUDIT STAIN DRUGS taxonomy or predefined NDC or class codes (BQI STATIN MEDS CLASS or BQI STATIN NDC taxonomies).
- Hyperlipidemia: At least two primary or secondary POVs ever for ambulatory or hospitalization visits (not on the same date) or one instance on the Active Problem List.
  - Defined as ICD 272.0-272.9 (BQI HYPERLIPIDEMIA DXS taxonomy).
- LDL lab test value equal to or greater than (=>) 160 in past five years. Test is defined by the site in DM AUDIT LDL CHOLESTEROL TAX taxonomy or pre-defined LOINC Codes (BGP LDL LOINC CODES taxonomy).

- Total cholesterol value equal to or greater than (=>) 240 in past five years. Test is defined by the site in DM AUDIT CHOLESTEROL TAX taxonomy or predefined LOINC Codes (BGP TOTAL CHOLESTEROL LOINC taxonomy).
- Non HDL equal to or greater than (=>) 190 in past five years, defined as value of Total Cholesterol minus value of HDL, both results documented on the same date.

Evidence of Nephropathy defined as any one of the following:

- Patients with at least two instances (primary diagnosis POV, Procedure or CPT for ambulatory or hospitalization visits) or one instance on Active Problem List in past five years.
  - Defined as ICD 250.40-250.43; 403.0-405.01; 405.11; 405.91; 581.81; 582.9; 583.81; 584.5-586.; 588.0-588.9; 753.0-753.19; 791.0; V42.0; V45.1; V56.0-V56.8 (BGP NEPHROPATHY DXS taxonomy); *or*
  - ICD Procedures 38.95; 39.27; 39.42-39.43; 39.53; 39.93-39.95; 54.98; 55.4-55.69 (BGP NEPHROPATHY PROCEDURES taxonomy); *or*
  - CPTs 3066F; 36145; 36800-36815; 36818-36821; 36831-36833; 50300; 50320; 50340; 50360; 50365; 50370-50380; 90920-90921; 90924-90937; 90939-90940; 90945-90947; 90989; 90993; 90997; 90999; 99512; G0257; G0314-G0319; G0322-G0323; G0326-G0327; S9339 (BGP NEPHROPATHY CPTS taxonomy).
- Two Creatinine test results equal to or greater than (=>) 2.0 over past year, separated by at least 90 days. Creatinine test defined by the site in DM AUDIT CREATININE TAX taxonomy or predefined LOINC Codes (BGP CREATININE LOINC CODES).
- Two estimated GFR values less than or equal to (<=) 30 over past year, separated by at least 90 days. Estimated GFR test defined by the site in BGP GPRA ESTIMATED GFR TAX taxonomy or by LOINC Code 33914-3 (BGP ESTIMATED GFR LOINC taxonomy).

Triglyceride (TG) Test

Site defined Lab Tests: V Lab site defined tests in DM AUDIT TRIGLYCERIDE TAX taxonomy

LOINC Codes: V Lab as predefined in BGP TRIGLYCERIDE LOINC CODES taxonomy

Note: CPT Codes will not be used to identify this test because a result value is required.

Best Practice Prompt Text

TG Goal: On [date of test], patient's TG was [xx]. Consider intensified therapy.

Site Configurable? No.

B.51 CVD Significant Risk: TG Recommendation

Description Field Text

Default Status: On

Denominator: Patients with active CVD ASR tag (iCare) with most recent Triglyceride (TG) test result within the past five years is equal to or greater than 500.

Definition (Frequency): As needed when recent TG result is 500 or higher.

Logic Detail

CVD At Significant Risk tag (Proposed or Accepted). If patient is not categorized with either Known CVD or At Highest Risk and meets either of the following criteria:

- Greater than (>) age 18 and at least two CVD Risk Factors; or
- Male equal to or greater than age (=>) 45 *or* female equal to or greater than age (=>) 55; and at least 1 CVD Risk Factor.

CVD Risk Factor defined as any one of the following:

- Current Smoker: The patient has at least two primary or secondary POVs ever for ambulatory or hospitalization visits (not on the same date) or one instance on the Active Problem List or most recent tobacco Health Factor or CPT.
  - Smoking defined as ICD 305.1; 305.10-305.12 (old codes), or 649.00-649.04 (BGP SMOKER ONLY DXS) or health factors Current Smoker, Current Smoker & Smokeless, Cessation Smoker, Cessation Smoker and Smokeless (BGP SMOKING HLTH FACTORS taxonomy); CPT 99406, 99407, G0375 (old code), G0376 (old code), 1034F (BGP SMOKER CPTS).
- Prediabetes Metabolic Syndrome: The patient has at least two primary or secondary diagnosis POVs ever for ambulatory or hospitalization visits (not on the same date) or on one instance on the Active Problem List.
  - Defined as ICD 277.7 (BGP PRE DM MET SYN DX taxonomy).
- Hypertension: The patient has at least three primary or secondary diagnosis POVs for ambulatory or hospitalization visits separated by 90 days or one instance on the Active problem list.

  - Defined as ICD 401.0-401.9 (BGP HYPERTENSION DXS taxonomy).
- Obese: The adult patient's most recent BMI is equal to or greater than (=>) 30.
- High Blood Pressure: Two of last three non-ER blood pressures are Systolic equal to or greater than (=>) 140 or Diastolic equal to or greater than (=>) 90.
- Most recent HDL laboratory test is less than (<) 40 for men or less than (<) 45 for women. HDL defined by the site in DM AUDIT HDL TAX Taxonomy or predefined LOINC Codes (BGP HDL LOINC CODES).

Evidence of High Cholesterol defined as any one of the following:

- Prescription for Statin medication in the past year defined by the site in the DM AUDIT STAIN DRUGS taxonomy or pre-defined NDC or class codes (BQI STATIN MEDS CLASS or BQI STATIN NDC taxonomies).
- Hyperlipidemia: At least two primary or secondary POVs ever for ambulatory or hospitalization visits (not on the same date) or one instance on the Active Problem List.
  - Defined as ICD 272.0-272.9 (BQI HYPERLIPIDEMIA DXS taxonomy).
- LDL laboratory test value equal to or greater than (=>) 160 in past 5 years. Test is defined by the site in DM AUDIT LDL CHOLESTEROL TAX taxonomy or pre-defined LOINC Codes (BGP LDL LOINC CODES taxonomy).
- Total cholesterol value equal to or greater than (=>) 240 in past five years. Test is defined by the site in DM AUDIT CHOLESTEROL TAX taxonomy or predefined LOINC Codes (BGP TOTAL CHOLESTEROL LOINC taxonomy).
- Non HDL equal to or greater than (=>) 190 in past five years, defined as value of Total Cholesterol minus value of HDL, both results documented on the same date.

Evidence of Nephropathy defined as any one of the following:

- Patients with at least two instances (primary diagnosis POV, Procedure or CPT for ambulatory or hospitalization visits) or one instance on Active Problem List in past five years.
  - Defined as ICD 250.40-250.43; 403.0-405.01; 405.11; 405.91; 581.81; 582.9; 583.81; 584.5-586.; 588.0-588.9; 753.0-753.19; 791.0; V42.0; V45.1; V56.0-V56.8 (BGP NEPHROPATHY DXS taxonomy); *or*
  - ICD Procedures 38.95; 39.27; 39.42-39.43; 39.53; 39.93-39.95; 54.98; 55.4-55.69 (BGP NEPHROPATHY PROCEDURES taxonomy); *or*

  - CPTs 3066F; 36145; 36800-36815; 36818-36821; 36831-36833; 50300; 50320; 50340; 50360; 50365; 50370-50380; 90920-90921; 90924-90937; 90939-90940; 90945-90947; 90989; 90993; 90997; 90999; 99512; G0257; G0314-G0319; G0322-G0323; G0326-G0327; S9339 (BGP NEPHROPATHY CPTS taxonomy).
- Two Creatinine test results equal to or greater than (=>) 2.0 over past year, separated by at least 90 days. Creatinine test defined by the site in DM AUDIT CREATININE TAX taxonomy or predefined LOINC Codes (BGP CREATININE LOINC CODES).
- Two estimated GFR values less than or equal to (<=) 30 over past year, separated by at least 90 days. Estimated GFR test defined by the site in BGP GPRA ESTIMATED GFR TAX taxonomy or by LOINC code 33914-3 (BGP ESTIMATED GFR LOINC taxonomy).

Triglyceride (TG) Test

Site defined Lab Tests: V Lab site defined tests in DM AUDIT TRIGLYCERIDE TAX taxonomy

LOINC Codes: V Lab as predefined in BGP TRIGLYCERIDE LOINC CODES taxonomy

Note:	CPT Codes will not be used to identify this test because a result value is required.

Best Practice Prompt Text

TG Recommendation: On [date of test], patient's TG was greater than (>) 500 [xx]. Confirm fasting sample and strongly consider drug therapy to avoid pancreatitis.

Site Configurable? No.

B.52 CVD Significant Risk: Tobacco Use Intervention

Description Field Text

Default Status: On

Denominator: Patients with active CVD ASR tag (iCare) who are documented tobacco users (smoker or smokeless) with no documented tobacco intervention after most recent tobacco use diagnosis.

Definition (Frequency): As needed when no tobacco intervention is documented.

Logic Detail

CVD ASR tag (Proposed or Accepted). If patient is not categorized with either Known CVD or AHR and meets either of the following criteria:

- Greater than (>) age 18 and at least 2 CVD Risk Factors; or
- Male equal to or greater than age (=>) 45 *or* Female equal to or greater than age (=>) 55; and at least one CVD Risk Factor.

CVD Risk Factor defined as any one of the following:

- Current Smoker: The patient has at least two primary or secondary POVs ever for ambulatory or hospitalization visits (not on the same date) or one instance on the Active Problem List or most recent tobacco Health Factor or CPT.
  - Smoking defined as ICD 305.1; 305.10-305.12 (old codes), or 649.00-649.04 (BGP SMOKER ONLY DXS) or health factors Current Smoker, Current Smoker & Smokeless, Cessation Smoker, Cessation Smoker and Smokeless (BGP SMOKING HLTH FACTORS taxonomy); CPT 99406, 99407, G0375 (old code), G0376 (old code), 1034F (BGP SMOKER CPTS).
- Prediabetes Metabolic Syndrome: The patient has at least two primary or secondary diagnosis POVs ever for ambulatory or hospitalization visits (not on the same date) or on one instance on the Active Problem List.
  - Defined as ICD 277.7 (BGP PRE DM MET SYN DX taxonomy).
- Hypertension: The patient has at least three primary or secondary diagnosis POVs for ambulatory or hospitalization visits separated by 90 days or one instance on the Active problem list.
  - Defined as ICD 401.0–401.9 (BGP HYPERTENSION DXS taxonomy).
- Obese: The adult patient's most recent BMI is equal to or greater than (=>) 30.
- High Blood Pressure: Two of last three non-ER blood pressures are Systolic equal to or greater than (=>) 140 or Diastolic equal to or greater than (=>) 90.
- Most recent HDL laboratory test is less than (<) 40 for men or less than (<) 45 for women. HDL defined by the site in DM AUDIT HDL TAX Taxonomy or pre-defined LOINC Codes (BGP HDL LOINC CODES).

Evidence of High Cholesterol defined as any one of the following:

- Prescription for Statin medication in the past year defined by the site in the DM AUDIT STAIN DRUGS taxonomy or predefined NDC or class codes (BQI STATIN MEDS CLASS or BQI STATIN NDC taxonomies).

- Hyperlipidemia: At least two primary or secondary POVs ever for ambulatory or hospitalization visits (not on the same date) or one instance on the Active Problem List.
  - Defined as ICD 272.0-272.9 (BQI HYPERLIPIDEMIA DXS taxonomy).
- LDL lab test value equal to or greater than (=>) 160 in past five years. Test is defined by the site in DM AUDIT LDL CHOLESTEROL TAX taxonomy or pre-defined LOINC Codes (BGP LDL LOINC CODES taxonomy).
- Total cholesterol value equal to or greater than (=>) 240 in past five years. Test is defined by the site in DM AUDIT CHOLESTEROL TAX taxonomy or predefined LOINC Codes (BGP TOTAL CHOLESTEROL LOINC taxonomy).
- Non HDL equal to or greater than (=>) 190 in past five years, defined as value of Total Cholesterol minus value of HDL, both results documented on the same date.

Evidence of Nephropathy defined as any one of the following:

- Patients with at least two instances (primary diagnosis POV, Procedure or CPT for ambulatory or hospitalization visits) or one instance on Active Problem List in past five years.
  - Defined as ICD 250.40-250.43; 403.0-405.01; 405.11; 405.91; 581.81; 582.9; 583.81; 584.5-586.; 588.0-588.9; 753.0-753.19; 791.0; V42.0; V45.1; V56.0-V56.8 (BGP NEPHROPATHY DXS taxonomy); *or*
  - ICD Procedures 38.95; 39.27; 39.42-39.43; 39.53; 39.93-39.95; 54.98; 55.4-55.69 (BGP NEPHROPATHY PROCEDURES taxonomy); *or*
  - CPTs 3066F; 36145; 36800-36815; 36818-36821; 36831-36833; 50300; 50320; 50340; 50360; 50365; 50370-50380; 90920-90921; 90924-90937; 90939-90940; 90945-90947; 90989; 90993; 90997; 90999; 99512; G0257; G0314-G0319; G0322-G0323; G0326-G0327; S9339 (BGP NEPHROPATHY CPTS taxonomy).
- Two Creatinine test results equal to or greater than (=>) 2.0 over past year, separated by at least 90 days. Creatinine test defined by the site in DM AUDIT CREATININE TAX taxonomy or pre-defined LOINC Codes (BGP CREATININE LOINC CODES).
- Two estimated GFR values less than or equal to (<=) 30 over past year, separated by at least 90 days. Estimated GFR test defined by the site in BGP GPRA ESTIMATED GFR TAX taxonomy or by LOINC Code 33914-3 (BGP ESTIMATED GFR LOINC taxonomy).

Tobacco Use

- Health Factors: most recent V Health Factor TBD BGP TOBACCO USER HLTH FACTORS taxonomy

- Diagnoses (ICD Codes): V POV or Problem List 305.1; 305.1* (old codes); 649.00-649.04; V15.82 [BGP GPRA SMOKING DXS taxonomy]
- V Dental: ADA 1320
- Procedures (CPT Codes): V CPT 1034F, 1035F (BGP TOBACCO USER CPTS taxonomy]

Tobacco Intervention or Cessation

Procedures (CPT Codes): V CPT G0375, G0376, 4000F, 4001F [BGP TOBACCO INTERVENTION CPTS taxonomy]

Clinic: Visit Clinic Code 94 (Tobacco Cessation Clinic)

Patient Education Codes: V Patient Ed Codes containing “TO-,” “-TO,” “-SHS,” 305.1, 649.00-649.04

Site defined Medications: V Medications in BGP CMS SMOKING CESSATION MEDS taxonomy or med name containing “Nicotine Patch,” “Nicotine Polacrilex,” “Nicotine Inhaler,” or “Nicotine Nasal Spray”

NDC (National Drug Codes): V Medications as predefined in BGP CMS SMOKING CESSATION NDC taxonomy

V Dental: ADA 1320

Best Practice Prompt Text

Tobacco Cessation: Patient is documented as a current Tobacco User. Consider tobacco cessation intervention.

Site Configurable? No.

B.53 Hearing Inquiry

Description Field Text

Default Status: On

Denominator: All patients ages 65 and older.

Definition (Frequency): N/A. This prompt appears routinely once the patient is age 65.

Best Practice Prompt Text

Patient is over 64 years old. Consider inquiring about hearing difficulties at least every two years.

Site Configurable? Yes: ages only.

Tooltip Text

This patient is 65 or older and should be asked about hearing difficulties at least every two years.

B.54 Rubella Vaccination (Adult)

Description Field Text

Default Status: Off

Denominator: Patients who are not documented as immune or with no documented rubella immunization since age one year.

- Born in 1957 or later who are at least 18; *or*
- Females who were born in 1957 or earlier *and* are currently less than age 50 years

Note: No longer applicable

Definition (Frequency): Once at or after age one year.

Logic Detail

Rubella Vaccination:

- Immunization/CVX Codes: V Immunization or Refusal 3, 4, 6, 38, 94
- Rubella Immunity Status: Health Factor: V Health Factor category Rubella Immunity Status: Immune, Non-Immune, Indeterminate

Different messages are displayed based on the patient's documented Immunity Status.

Best Practice Prompt Text

A Rubella Immunization is due after age onr; this adult (18+) patient born in 1957 or later has no document immunization. |RUBELLA|

Currently Define Criteria is Use at this Facility

Tooltip Text

A rubella immunization is due after age one; this adult (18+) patient born in 1957 or later has no documented immunization.

B.55 Strabismus/Amblyopia Screen

Description Field Text

Default Status: On

Denominator: All patients from ages 2 to 3 years.

Definition (Frequency): One time. This prompt will continue to appear for patients through age 4 years, until the test is documented.

Best Practice Prompt Text

Consider checking for strabismus and amblyopia.

Site Configurable?: No.

Tooltip Text

The U.S. Preventive Services Task Force (USPSTF) recommends screening children younger than five years for amblyopia, strabismus, and visual acuity.

Appendix C: Asthma Supplement Logic

Below is the logic for the Asthma Supplement.

Section Name: Heading

Order: 1

Description: Displays general information about the patient and facility.

Logic/Source

1st row: Standard printed report header "Confidential Patient Information"; report date and time; user initials

2nd row: "Asthma Patient Care Summary"; page number

3rd row: Patient last name, first name; HRN

4th row: DOB; Age; Sex; Asthma Diagnostic Tag: [Tag Status], if current status is Proposed or Accepted] or "None" or–if site is not running iCare, text should be "Data Not Available"

5th row: Patient's assigned providers from the Designated Specialty Provider Management (BDP) application

Note:	The Supplement should observe the same business rule about displaying the HIV Provider as will be applied to Health Summary.

Section Name: Heading Pages 2 and up

Order: 2

Description: Displays at the top of the summary if the summary is more than one page.

Logic/Source

1st row: "Confidential" header as above

2nd row: "Asthma Patient Care Summary"; Page #

Section Name: Problem List

Order: 3

Description: Indicates whether asthma diagnosis is on the patient's problem list, with (1) a classification (Asthma Severity); (2) an onset date, if any, (3) date record was last updated; and (4) any associated notes.

Logic/Source

Logic: Patient, who has a Problem List diagnosis (ICD code) of Asthma, defined as taxonomy BGP ASTHMA DXS.

Display Text: If the criteria is met, the system displays [Problem ID] [Provider narrative] ([ICD DX code]), e.g. “DIH3 Asthma (493.90)”

Asthma Severity: [value] or “None Documented”

Date of Onset: [Date of Onset] or “None Documented”

Date Last Updated: [Date Last Updated]

Note ID: Entry Date (if any) Note Narrative. If the criterion is not met, the system displays: “ASTHMA IS NOT ON THIS PATIENT'S PROBLEM LIST; CONSIDER ADDING.”

Section Name:

Order: 4

Description:

Logic/Source

Section Name: Most Recent Control

Order: 5

Description: Displays the patient’s most recent asthma control and the date documented.

Logic/Source

V Asthma: Control field – most recent documented

Display: “Most Recent Control: [Visit Date] [Control]

Section Name: Asthma-Related Family Health History

Order: 6

Description: Displays any documented family history related to asthma, using same display as Health Summary

Logic/Source

If FamHX diagnosis for any Relation is V17.5 or defined in BGP ASTHMA DXS, display the Health Summary format

If none, display “None Documented”

Section Name: Personal Best Peak Flow

Order: 7

Description: Displays the patient's highest BPF measurement and date documented.

Logic/Source

V Measurements: BPF field–review all documented values and display the highest number

Display: "Personal Best Peak Flow [value] on [Visit Date]" or "None Documented"

Section Name: Peak Flow Zones

Order: 8

Description: Displays hard-coded text explaining the "green," "yellow," and "red" zones for peak flow measurements.

Also displays the patient's BPF calculation for the green, yellow, and red zone. This calculation is also calculated in the AAP.

Logic/Source

Use the patient's highest BPF, if any, to calculate and display the three zones defined below.

Display:

Green (80–100%): xx–xx liters/minute

Yellow (50–79%): xx–xx liters/minute

Red (< 50%): < xx liters/minute

If no BPF, display "Peak Flow Zones could not be calculated; BPF must be documented."

Section Name: Date of last AAP

Order: 9

Description: Displays the date of the last AAP.

Logic/Source

The Action Plan is in the process of being moved from BAT to Patient Education, once the DBA releases the new PatEd AUPN patch. The supplement may need to look at both sources.

BAT Source

Pull from FILE: ASTHMA REGISTER / GLOBAL: ^BATREG(/ FILE #: 90181.01

File #: .093

File Name: DATE OF ASTHMA MANAGEMENT PLAN

Subscript: COMPUTED

PED Source

V PED–ASM-SMP value

Display: “Date of Last Asthma Action Plan [visit date or BAT data]

If there is no date, “Needs to be reviewed” displays. If the date has exceeded one year, add “Needs to be reviewed” after the date.

Section Name: Triggers

Order: 10

Description: Displays the most recent entry for each asthma trigger, and date.

Logic/Source

V Health Factors: Asthma Triggers category

Section Name: Last Recorded Tobacco Health Factor

Order: 11

Description: Displays the most recent Tobacco Health Factor and the date entered.

Logic/Source

V Health Factors: Tobacco category

Display: “Last Recorded TOBACCO Health Factor: [Visit Date] [Health Factor]

Section Name: Last 5 Visits with Lung Function Measurements

Order: 12

Description: Displays the last five visits in which lung function measurements (FEV1/FVC, Peak Flow, FEF 25–75) were documented.

Logic/Source

V Measurements

Lung function measurements are:

1st column: [Visit Date]

2nd column: FEV1/FVC (FVFC)–Displays both values, then the calculations (e.g., 4/6 (0.66)). If there are multiple values for a single visit, display the highest number.

3rd column: Highest Visit Peak Flow–If there are multiple values for a single visit, display the highest number.

4th column: FEF 25–75 (FEF)

See example Asthma Supplement below for guidance.

Section Name: Asthma Symptom Free Days

Order: 13

Description: Displays results from the last three visits in the past year, and date recorded.

Logic/Source

V Measurements: ASFD

Display Visit Date and # of Days

In addition, if most recent visit is more than one year old, then the following displays: "Asthma Symptom Free Days should be reviewed at every Asthma visit."

Section Name: Asthma Work/School Days Missed

Order: 14

Description: Displays results from the last three visits in the past year, and date recorded.

Logic/Source

V Measurements: ADM

In addition, if last visit is more than one year old, then the following displays: "Asthma work/school days missed should be reviewed at every Asthma visit."

Section Name: Number of Reliever Fills in past 6 months

Order: 15

Description: Displays tally of Reliever Fills in the past 6 months.

Logic/Source

Source: V Medication

Logic: Counts number of prescribed medications in past six months (183 days) as defined in any of the following taxonomies:

- BAT ASTHMA SHRT ACT RELV NDC
- BAT ASTHMA SHRT ACT RELV MEDS
- BAT ASTHMA SHRT ACT INHLR NDC
- BAT ASTHMA SHRT ACT INHLR MEDS
- BGP RA GLUCOCORTIOCOIDS
- BGP RA GLUCOCORTIOCOIDS CLASS

Order: 16

Section Name: Number of Controller Fills in Past 6 Months

Description: Displays a list of Controller Fills in the past six months.

Logic/Source

Source: V Medication

Logic: Counts number of prescribed medications in past six months (183 days) as defined in any of the following taxonomies:

- BAT ASTHMA CONTROLLER MEDS
- BAT ASTHMA CONTROLLER NDC
- BAT ASTHMA INHALED STEROIDS
- BAT ASTHMA INHLD STEROIDS NDC
- BAT ASTHMA LEUKOTRIENE MEDS
- BAT ASTHMA LEUKOTRIENE NDC

Section Name: Asthma Medications (Replaced by Two Separate Sections: Reliever Medications (Filled in Last Six Months) and Controller Medications (Filled in Last Six Months)

Order: 17

Description: Displays asthma-related prescriptions filled in the past six months, organized by Relievers, then Controllers.

Add legend/key to the top of the listing that identifies the information in each column: Date filled, Status, Medication name, strength, instructions, # of times filled this year, # of refills left.

Add two more character spaces on the date to ensure that there is enough room for MM/DD/YYYY format. The current supplement cuts off dates with this format.

Logic/Source

Prescribed asthma-related medications for the past six months (183 days), organized by Relievers and Controllers.

V Medication

Relievers defined as:

- BAT ASTHMA SHRT ACT RELV NDC
- BAT ASTHMA SHRT ACT RELV MEDS
- BAT ASTHMA SHRT ACT INHLR NDC
- BAT ASTHMA SHRT ACT INHLR MEDS
- BGP RA GLUCOCORTIOCOIDS
- BGP RA GLUCOCORTIOCOIDS CLASS

Controllers defined as:

- BAT ASTHMA CONTROLLER MEDS
- BAT ASTHMA CONTROLLER NDC
- BAT ASTHMA INHALED STEROIDS
- BAT ASTHMA INHLD STEROIDS NDC
- BAT ASTHMA LEUKOTRIENE MEDS
- BAT ASTHMA LEUKOTRIENE NDC

Section Name: Last of each Asthma Patient Education Done

Order: 18

Description: Displays the most recent of each asthma-related patient education events. Displays the education mnemonic, topic, level of understanding, date of education, and any goals data.

Add legend/key to the top of the listing that identifies the information in each column.

Logic/Source

Include any V PED topics:

- ASM-*
- 493*-*

  - PL
  - M-MDI
  - M-NEB
- Display as three columns: Topic, Level of Understanding, and Date
- Display goal code and goal comment on indented line underneath
- Sort alphabetically by topic.

Appendix D: Health Factors

Please refer to the "Health Factor and Exam Codes Documentation Guide" for a complete listing of Health Factors and guidance for assessing and documenting results.

Appendix E: Exam Codes

Please refer to the "Health Factor and Exam Codes Documentation Guide" for a complete listing of Exam Codes and guidance for assessing and documenting results.

Appendix F: Health Summary Form

Use this form as a guide to help you plan for and request a new health summary type.

To: Health Summary Coordinator/Site Manager

From:

Instructions for filling out this request form*:* Please complete *all* of the items below. Identify the order in which the component should display, the name of the component, any alternate name you would like displayed, the maximum number of occurrences and the time limit for display of data, and any specific items that need to be selected individually. Note that you will need to specify individual items for the lab test, health factors, and HMR components. You will also need to indicate the names of any measurement panels or flowsheets, if you have chosen these components.

Health Summary Type Name:

Order	Component Name	Component Name to Displays	Maximum Occurrences	Time Limit	Selection Items (as applicable)

ICD Text Display: ___ Long ___ Short ___Code Only ___None

Provider Narrative Displayed? ___ Yes ___ No

Clinic Name Displayed? ___ Yes ___ No

Appendix G: Health Summary Data Components

Health Summaries are composed of a series of data groupings called *components*. These components encompass a wide variety of information regarding a patient's health status. Each component represents a major class of PCC data; for example, active problems or measurements.

The following list contains the components that appear in the Health Summaries. Many of these components are displayed in the standard Health Summaries distributed with this package. These components can be used to create customized Health Summaries that meet the needs of providers at the user's facility. (Refer to the Section 3.6 of this manual for detailed instructions on developing customized health summaries.)

Some of these components can be modified to display only certain types and amounts of data; for instance, the last two years of only height and weight values in the Measurement Panel. Different components might display the same class of data in different ways; for example, the ten most recent outpatient visits or all outpatient visits during the past five years.

Each of the following components is described in detail in this section. A sample printout of each is provided for reference.

- ACTIVE WAIT LIST ENTRIES
- ALLERGIES (FROM PROBLEM LIST)
- ALLERGIES/ADVERSE REACTIONS (B
- ALLERGIES/ADVERSE REACTIONS (D
- BEHAVIORAL HEALTH
- BEST PRACTICE PROMPTS
- BLOOD BANK–MOST RECENT
- CHR
- CPT–ALL BY CPT CODE
- CPT–ALL BY DATE
- CPT–MOST RECENT OF EACH
- DEMOGRAPHIC DATA
- DEMOGRAPHICS–BRIEF
- DEMOGRAPHICS–W/ADV DIR
- DEMOGRAPHICS–W/O REMARKS

- DENTAL
- DIAGNOSTIC PROCEDURE
- DIRECTIONS TO PATIENT HOME
- EDUCATIONAL ASSESSMENT
- ELDER CARE 1
- ELDER CARE 2
- EXAMINATIONS - MOST RECENT
- EYE CARE
- FAMILY HEALTH HISTORY
- FLOWSHEETS
- HEALTH FACTORS
- HEALTH MAINTENANCE REMINDERS
- HISTORY OF MINOR SURGERY
- HISTORY OF SURGERY
- HOSPITALIZATION STAYS
- IMAGING
- IMMUNIZATIONS
- IN-HOSPITAL VISITS
- INFANT FEEDING CHOICE PANEL
- INSURANCE INFORMATION
- LAB DATA - MOST RECENT BY DATE
- LABORATORY DATA
- LABORATORY DATA - MOST RECENT
- MEASUREMENT PANELS
- MEASUREMENTS
- MEDICATION RECONCILIATION
- MEDS–ALL
- MEDS–ALL W/#ISS & ALT NAME
- MEDS–ALL WITH # ISSUED
- MEDS–CHRONIC

- MEDS–CHRONIC & ACUTE W/ ISSU
- MEDS–CHRONIC BY NAME
- MEDS–CHRONIC EXCLUDING D/C'E
- MEDS–CONTROLLED SUBSTANCES
- MEDS–CURRENT
- MEDS–CURRENT BY NAME
- MEDS–MOST RECENT BY GROUP
- MEDS–MOST RECENT OF EACH
- MEDS–MOST RECENT SHORT FORM
- MICROBIOLOGY
- NARRATIVE TEXT
- NUTRITIONAL RISK SCREENING EXAM
- OFFSPRING HISTORY
- OUTPATIENT VISITS (EXCL CHR)
- OUTPATIENT VISITS (SCREENED)
- OUTPATIENT/FIELD VISITS
- PATIENT ED–MOST RECENT
- PATIENT ED–MOST RECENT BY TO
- PATIENT EDUCATION
- PATIENT GOALS
- PATIENT WELLNESS HANDOUT
- PATIENT WELLNESS HANDOUT TALLY
- PERSONAL MEDICAL HISTORY
- PRENATAL
- PRENATAL (ACOG)
- PROBLEMS–ACTIVE
- PROBLEMS–INACTIVE
- PSOALLERGIES
- PUBLIC HEALTH NURSING VISITS
- RADIOLOGY–MOST RECENT

- RADIOLOGY EXAMS
- RADIOLOGY IMAGING
- REFERRED CARE
- REFUSALS/DECLINED SERVICES
- REFUSALS/DECLINED SERVICES MOST RECENT OF EACH
- REPRODUCTIVE HISTORY – ALL EDD
- REPRODUCTIVE HISTORY - BRIEF
- SCHEDULED ENCOUNTERS (W/CHART
- SCHEDULED ENCS (W/O CHART REQ
- SKIN TESTS–ALL
- SKIN TESTS–LAST 3 OF EACH
- SUPPLEMENTS
- TREATMENT CONTRACTS
- TREATMENTS PROVIDED
- WELL CHILD EXAM

G.1 Display Format

The separate components of a Health Summary are delineated by dividing lines that frame the individual component headings. For example

```
------------------------- DEMOGRAPHIC DATA -----------------------
```

Figure G-1: Example display format

If no data exist for a given component, the component heading will not appear. If data for a component exist, but have subsequently fallen outside the component's restrictions of time or number of occurrences, then a heading appears, but no data are displayed. For example, the Most Recent Laboratory Data component displays laboratory results for the past two years only. If the patient had a glucose test taken three years ago and no other laboratory tests since then, this test result would not print in the Health Summary. Instead, only the component heading would display. However, if a patient has never had any laboratory tests, no heading will display.

Whether the Health Summary is printed or displayed on a video terminal, it will have a standard heading (see Figure G-2) that contains the following information on each page:

- Date and time the summary was produced

- Initials of the person who requested the report
- Patient's name
- Health Record Number
- Health summary type
  - Page number

```
CONFIDENTIAL PATIENT INFORMATION -- MAY 3,1996 1:09 PM [CKC]
*** METAA,BETTY ANN #000000 (ADULT REGULAR SUMMARY) pg. 1 ***
```

Figure G-2: Example heading

G.2 Data Restrictions

It is not always useful to display all of the data that exist for a given component, since some of the data might be very old and therefore irrelevant in planning for the care of the individual patient. For instance, a 65-year-old patient who has been receiving services at the user's facility for 20 years will have had many visits during that time period. The user would probably not want all of these visits printed for the Outpatient/Field Visits component of the Health Summary. For this reason, the user will want to restrict the amount of data that will print for each component. For instructions on restricting the data that displays for each component, see the Supervisory Functions section.

The data displayed for each component can be restricted in the following manner:

- Specify the maximum number of occurrences to display for a component. For example, the following component is limited to the last five recorded visits.

```
---------- OUTPATIENT/FIELD VISITS (max 5 visits) -----------------
```

Figure G-3: Example of maximum visits

- Place a time restriction on the component. This restriction can be expressed in days, weeks, months, or years. In Figure G-4, only the visits that occurred within the past year will be printed.

```
---------------- OUTPATIENT/FIELD VISITS (1 year) -----------------
```

Figure G-4: Example of time restriction

- Both the number of occurrences and the time period can be specified for a single component. When you have placed these two types of restrictions on a component, only the more restrictive of the two limits applies. In Figure G-5, the Outpatient/Field Visits were restricted to a maximum of ten occurrences or to the last two years. If the last 10 visits occurred within the past two years, all of the visits would print. If only four visits occurred in the past two years, although the patient had 10 total visits, only four visits would print.

```
-------- OUTPATIENT/FIELD VISITS (max 10 visits or 2 years) --------
```

Figure G-5: Example of number of occurrences and time period

Note that for each component, the data restriction displays, as shown in the previous examples. If no restrictions have been placed on the data to be displayed, no notation will display in the heading and all data in that class will be displayed, as shown below.

```
------------------ OUTPATIENT/FIELD VISITS ------------------------
```

Figure G-6: Example of no notation

The components included in the standard Health Summaries distributed with this package already contain restrictions on the data that will display for each.

G.3 Active Wait List

The Active Wait List component displays the wait list entries for the patient that was entered in the PIMS module.

```
---------------- ACTIVE WAIT LIST ENTRIES -------------------------

 Date Added/Recall Date Wait List Name  Provider   Priority
NOV 17, 2009/NOV 17, 2009 GENERAL    QVPROVIDER,BONNIE HIGH
```

Figure G-7: Example of Active Wait List component

G.4 Allergies (from Problem List)

The Allergies (from Problem List) component highlights the patient's medication allergies typed into the PCC database in the patient's active Problem List. If an allergy is recorded in the Problem List, it will display in the Allergies (from Problem List) component, as in below:

```
---------------- ALLERGIES (FROM PROBLEM LIST) --------------------

***** NO ASA, TYLENOL, ADVIL - GI UPSET *****
```

Figure G-8: Example of the Allergies component

This component can also be used to identify patients with no known allergies. If an ICD code of 799.9 *and* a narrative of NKA or No Known Allergy are on the patient's Problem List, the message "No Allergy Noted" displays, along with the date on which the code and narrative were entered into the PCC, as shown below:

```
-------------------- ALLERGIES (FROM PROBLEM LIST) ----------------

NO ALLERGY NOTED ON JAN 7, 1995
```

Figure G-9: Example of No Allergy Noted message

If no allergies were recorded in the patient's Problem List, the message "None Recorded" displays, as in Figure G-10.

```
----------------- ALLERGIES (FROM PROBLEM LIST) --------------------

***** NONE RECORDED *****
```

Figure G-10: Example of None Recorded message

Note that the information that displays in this section is entirely dependent on proper coding and the provider's narrative.

Note that instead of deleting a problem from the list (as had been done in the past), the status field is set to D for deleted.

G.5 Allergies/Adverse Reactions (Brief) and Allergies/Adverse Reactions (Detailed)

Both the Allergies/Adverse Reactions (Brief) and Allergies/Adverse Reactions (Detailed) components list the patient's allergies and adverse reactions that were entered into the RPMS database. Allergies/Adverse Reactions components include date of last allergy list review, provider doing the review, and last documented "No Active Allergies." Inactive Allergies/Adverse Reactions do not display.

Figure G-11 is an example of the Allergies/Adverse Reactions (Brief) component display.

```
--- ALLERGIES/ADVERSE REACTIONS (BRIEF) (FROM ALLERGY TRACKING) ----

Adverse Reactions: SULFAMETHOXAZOLE (verified) - HIVES, RASH
```

Figure G-11: Example of brief allergies/adverse reactions component

Figure G-12 is an example of the same allergy/adverse reaction data in the Allergies/Adverse Reactions (Detailed) component display.

```
-- ALLERGIES/ADVERSE REACTIONS (DETAILED) (FROM ALLERGY TRACKING)---

ADVERSE REACTIONS:
noted: 2/4/08 SULFAMETHOXAZOLE    (verified)--HIVES, RASH
```

Figure G-12: Example of detailed allergies/adverse reactions component

The Allergies/Adverse Reactions (Detailed) component lists more in-depth information than Allergies/Adverse Reactions (Brief), such as status of whether it was verified as an adverse reaction and the date it was entered.

G.6 Behavioral Health

The Behavioral Health component reports information that was typed into the PCC database regarding active problems, inactive problems, and screenings related to behavioral health. You can restrict the display data by specific time range and/or number of visits. In the following example, the data is restricted to a maximum of 10 visits or seven years:

```
--------- BEHAVIORAL HEALTH (max 10 visits or 7 years) ------------
******************** BH ENCOUNTERS ********************
04/26/07 DEMO IND OPC 314.00 - ATTENTION-DEFICIT/HYPERACTIVITY DIS.
04/09/02 DEMO IND SMI OPC 62 - OTHER FAMILY LIFE PROBLEM

******************** BH ACTIVE PROBLEMS ********************
1 01/11/08 (311.)  DEPRESSIVE DISORDER NOS
       major depression, recurrent (ONSET: 05/12/02)
2 01/11/08 (309.81) POST-TRAUMATIC STRESS DISORDER
      PTSD (ONSET: 11/24/03)


******************** BH INACTIVE PROBLEMS ********************
<NONE>

********* BH Screening Exams *********
<NONE>
```

Figure G-13: Example of Behavioral Health Component

G.7 Blood Bank–Most Recent

The Blood Bank–Most Recent component reports information that has been typed into the PCC database regarding blood bank data for a specified date range.

G.8 Community Health Representative (CHR)

The CHR component reports information that has been entered into the IHS Community Health Representative Reporting system by Community Health Representatives (CHRs). Only data recorded in this system will display. For instance, if a CHR did not record the patient's evaluation, no evaluation will display in the component. Unlike most other Health Summary components, the data displayed in this component is not retrieved from the PCC database, but directly from the CHR system.

The component displays the date of service, place of service, the CHR's initials, purpose of visit, services provided, activity time, the CHR's Service Unit, evaluation, and any referrals that correspond with the visit. These data items are shown in Figure G-14.

```
---------------- CHR (max 10 visits or 2 years) -------------------

07/14/06 HOME TS DIABETES MELLITUS (DM) - MONITOR PATIENT AT: 30
PT experiencing dizziness; referred to doctor
Referred BY: MEDICAL Referred TO: CHR

09/24/07 HOME HC MOVEMENT PROBLEM (MP) - PATIENT CARE AT: 15
Left leg - limited mobility after fall

10/31/07 COMMUNITY BD HYPERTENSION (HY) - HEALTH EDUCATION AT: 50
BP taken: 120/80. PT taking meds
EVALUATION: LEVEL OF UNDERSTANDING IMPROVED
```

Figure G-14: Example of CHR component

G.9 CPT Components

CPT (All by CPT Code), CPT (All by Date), and CPT (Most Recent of Each)

The components related to Current Procedural Terminology (CPT) display the CPT code, date, CPT narrative, units, facility, and clinic associated with specific patient CPTs. The display data can be restricted by specific time range and/or number of visits. In Figure G-15, the data is restricted to a maximum of five visits or two years.

```
----------- CPT - ALL BY CPT CODE (max 5 visits or 2 years) -------

90471 09/18/06 IMMUNIZATION ADMIN    1  DEMO HO PED
90472 09/18/06 IMMUNIZATION ADMIN, EACH ADD 1  DEMO HO PED
  09/18/06 IMMUNIZATION ADMIN, EACH ADD 1  DEMO HO PED
  09/18/06 IMMUNIZATION ADMIN, EACH ADD 1  DEMO HO PED
90633 09/18/06 HEP A VACC, PED/ADOL, 2 DOSE 1  DEMO HO PED
90700 09/18/06 DTAP VACCINE, < 7 YRS, IM  1  DEMO HO PED
90707 09/18/06 MMR VACCINE, SC    1  DEMO HO PED
```

```
90713 09/18/06 POLIOVIRUS, IPV, SC/IM   1  DEMO HO PED
94760 07/26/07 MEASURE BLOOD OXYGEN LEVEL  1  DEMO HO  ER
99213 11/03/06 OFFICE/OUTPATIENT VISIT, EST 1  DEMO HO GEN
99392 09/18/06 PREV VISIT, EST, AGE 1-4  1  DEMO HO PED

------------- CPT - ALL BY DATE (max 5 visits or 2 years) ----------
       CODE CPT NARRATIVE     UNITS
07/26/07 DEMO HO  ER 94760 MEASURE BLOOD OXYGEN LEVEL  1
11/03/06 DEMO HO  GEN 99213 OFFICE/OUTPATIENT VISIT, EST 1
09/18/06 DEMO HO  PED 90471 IMMUNIZATION ADMIN    1
   DEMO HO  PED 90472 IMMUNIZATION ADMIN, EACH ADD 1
   DEMO HO  PED 90472 IMMUNIZATION ADMIN, EACH ADD 1
   DEMO HO  PED 90472 IMMUNIZATION ADMIN, EACH ADD 1
   DEMO HO  PED 90633 HEP A VACC, PED/ADOL, 2 DOSE 1
   DEMO HO  PED 90700 DTAP VACCINE, < 7 YRS, IM  1
   DEMO HO  PED 90707 MMR VACCINE, SC     1
   DEMO HO  PED 90713 POLIOVIRUS, IPV, SC/IM   1
   DEMO HO  PED 99392 PREV VISIT, EST, AGE 1-4  1

--------- CPT - MOST RECENT OF EACH (max 5 visits or 2 years) ------

CODE DATE  CPT NARRATIVE     UNITS FACILITY CLN
90471 09/18/06 IMMUNIZATION ADMIN   1  DEMO HO PED
90472 09/18/06 IMMUNIZATION ADMIN, EACH ADD 1  DEMO HO PED
90633 09/18/06 HEP A VACC, PED/ADOL, 2 DOSE 1  DEMO HO PED
90700 09/18/06 DTAP VACCINE, < 7 YRS, IM  1  DEMO HO PED
90707 09/18/06 MMR VACCINE, SC    1  DEMO HO PED
90713 09/18/06 POLIOVIRUS, IPV, SC/IM  1  DEMO HO PED
94760 07/26/07 MEASURE BLOOD OXYGEN LEVEL 1  DEMO HO ER
99213 11/03/06 OFFICE/OUTPATIENT VISIT, EST 1  DEMO HO GEN
99392 09/18/06 PREV VISIT, EST, AGE 1-4  1  DEMO HO PED
```

Figure G-15: Example of CPT components

G.10 Demographics Components

The following provides information about the various demographic components.

Note that there are two new site parameters related to the Remarks section of the health summary. The first site parameter allows a site to specify how many lines of Remarks (Additional Patient Registration Information) will display in the Demographic component of the health summary. The second site parameter allows a site to define whether the first or last number of lines will display.

G.10.1 Demographic Data

The information displayed in the demographics components is extracted from the RPMS Patient Registration database. The data shown can be used by providers to identify and locate patients, as well as to plan contract services.

Each demographics component displays a different amount of demographic-related information.

Demographic Data displays the information listed below:

Line Number	Data Items Displayed
1	• Patient Name • Date of birth • Age • Sex • Blood type
2	• Patient's Tribal affiliation • Last four digits of the Social Security Number
3	• Mother's maiden name
4	• Home phone number • Work phone number • Father's name
5	• Preferred Language • Preferred Method Of Receiving Reminders • Patient's community of residence • Mailing address
6	• Date that registration information was last updated • Information regarding patient's eligibility to receive date: Ineligible: Cannot receive healthcare services at this facility Direct: Can receive healthcare services at this facility, but is not Eligible to receive contract health services
7	• Veteran status
8	• Information regarding privacy practices: • Notice of privacy practices received by patient? Yes/No (Y/N) • Date received patient (MMM DD, YYYY) • Was acknowledgement signed? Yes/No (Y/N)
9	• Patient's health record numbers with facility designation

Line Number	Data Items Displayed
10	• Designated provider, if assigned
11	• Remarks that were entered into the Additional Registration field in the Patient Registration System
12	• Any Case Management System registers of which the patient is a member **Note**: Registers classified as confidential will not display.

G.10.2 Demographics – Without Remarks

Demographic Data–Without Remarks displays the information listed below:

Line Number	Data Items Displayed
1	• Patient Name • Date of birth • Age • Sex • Blood type
2	• Patient's tribal affiliation • Social Security Number
3	• Mother's maiden name
4	• Home phone number • Work phone number • Father's name
5	• Preferred Language • Preferred Method Of Receiving Reminders • Patient's community of residence
6	• Date that registration information was last updated • Information regarding patient's eligibility to receive date: Ineligible: Cannot receive healthcare services at this facility Direct: Can receive healthcare services at this facility, but is not Eligible to receive contract health services

G.10.3 Demographics–Brief

The Demographics–Brief component is a subset of the data displayed in the Demographic Data component. The information in this component is obtained from the Patient Registration database and includes the following fields:

- NAME
- DOB
- AGE
- TRIBE
- HEALTH RECORD NUMBER
- ADDRESS
- PHONE
- WORK PHONE
- PREFERRED LANGUAGE
- PREFERRED METHOD OF RECEIVING REMINDERS
- ELIGIBILITY
- ADVANCE DIRECTIVES
- LAST UPDATED

The requester is unsure if the SSN should also be included.

In Figure G-16, the first section displays the Demographics–Brief information, the second section displays the Demographic Data information, and the third section displays the Demographics – W/O Remarks information.

```
******* CONFIDENTIAL PATIENT INFORMATION -- 10/22/2010 11:20 AM
[LAF] *******
***************** TEST,HUEY #886988    (FELIX SUMMARY)  pg 1
*****************

---------------- BRIEF DEMOGRAPHICS ----------------------------


TEST,HUEY    DOB: AUG 15,1982    SSN: XXX-XX-7777
2010 DEMO HOSPITAL HEALTH RECORD NUMBER: 886988
Home Phone: None     Work Phone: None
Preferred Language: FRENCH CANADIAN

Preferred Method of Receiving Reminders: EMAIL

----------------- DEMOGRAPHIC DATA -----------------------------
```

```
TEST,HUEY                          DOB: AUG 15,1982 28 YRS  MALE
no blood type
ALEUT COMM ST. PAUL & ST. GEORGE  SSN: XXX-XX-7777
<no phone numbers recorded>
                                   PREFERRED LANGUAGE: FRENCH
CANADIAN
TUCSON

LAST UPDATED: SEP 24,2010         ELIGIBILITY: DIRECT ONLY

NOTICE OF PRIVACY PRACTICES REC'D BY PATIENT?  NO
                    DATE RECEIVED BY PATIENT:
                  WAS ACKNOWLEDGEMENT SIGNED?  YES

HEALTH RECORD NUMBERS:  886988  2010 DEMO HOSPITAL
DESIGNATED PRIMARY CARE PROVIDER: <none identified>

Preferred Method of Receiving Reminders: EMAIL

--------------------- DEMOGRAPHICS -----------------------------
TEST,HUEY                          DOB: AUG 15,1982 28 YRS  MALE
no blood type
ALEUT COMM ST. PAUL & ST. GEORGE  SSN: XXX-XX-7777

<no phone numbers recorded>
                                   PREFERRED LANGUAGE: FRENCH
CANADIAN
TUCSON

LAST UPDATED: SEP 24,2010         ELIGIBILITY: DIRECT ONLY

Preferred Method of Receiving Reminders: EMAIL
```

Figure G-16: Example of Demographics components

Demographics–Brief with Advanced Directives

The Demographics–Brief w/Advance Directions component is a subset of the data displayed in the Demographic Data component. The information in this component contains Advance Directives information obtained from the Patient Registration database:

- NAME
- SEX
- DOB
- AGE
- SSN
- TRIBE
- ELIGIBILITY

- LOCATION
- HEALTH RECORD NUMBER
- ADDRESS
- PHONE
- WORK PHONE
- PREFERRED LANGUAGE
- PREFERRED METHOD OF RECEIVING REMINDERS
- ADVANCE DIRECTIVES
- LAST UPDATED
- LAST REGISTRATION UPDATE
- CMS REGISTER AND STATUS

```
--------- DEMOGRAPHICS - BRIEF W/ADV DIRECTIVES -------------------

DEMO, PATIENT MALE DOB: JAN 4,1993 AGE: 16 SSN: XXX-XX-3748
TRIBE: DOWN EAST BAND OF LOCALS IND. RES., MN  CHS & DIRECT
DEMO HOSPITAL HEALTH RECORD NUMBER: 111111
PO BOX 444,SOMEWHERE,MN,56671
Home Phone: 555-555-6575  Work Phone: None
Preferred Language: FRENCH CANADIAN
Preferred Method of Receiving Reminders: EMAIL
Advance Directives: YES LIVING WILL Updated: DEC 01, 2009
Last Registration Update: DEC 01, 2009
ON CMS REGISTER(S): ASTHMA (PERSISTENT) Status: ACTIVE
```

Figure G-17: Example of Demographics - Brief w/Advance Directives component

G.11 Dental

The Dental component displays a detailed dental services history that includes the dental visit date, site of service, ADA procedure code, and procedure description for encounters that fall within the time and occurrence constraints (see Figure G-18). The information for this component is extracted from the IHS Dental package.

```
--------------- DENTAL (max 3 visits or 1 year) -------------------

FAILED DENTAL APPOINTMENTS:
04/21/97 CANCELLED
03/28/97 BROKEN
02/20/97 BROKEN

ACTIVE DENTAL FOLLOWUP SUMMARY:
09/20/90 ROUTINE RECALL LIST Action: 09/20/91

<No Previous Followup>
     SERVICES PROVIDED:
06/04/07 DEMO HO --SMITH,JOHN-- (Provider: DOE,JOHN)
 1110 ( 1) PROPHY ADULT
 1204 ( 1) TFw/oPROPHY-AD.
 1330 ( 1) ORAL PREV PLAN
 0150 ( 1) ORAL EXAM INIT.
 0190 ( 1) DENTAL REVISIT
 0274 ( 1) BW X-RAY (4)
```

Figure G-18: Example of Dental component

G.12 Diagnostic Procedure

This component displays EKG/ECG summaries within the date and time restrictions specified. The date of the procedure, EKG/ECG summary, and the results display.

```
------------- DIAGNOSTIC PROCEDURE (max 10 visits) ----------------

09/01/05 ECG SUMMARY RESULT: NORMAL
```

Figure G-19: Example of Diagnostic Procedure component

G.13 Directions to the Patient’s Home

This component prints directions to the patient’s home that have been entered in the Patient Registration System.

```
----------------DIRECTIONS TO PATIENT HOME------------------------


Take I-11, then exit at Springfield.
Turn right at the bottom of the ramp, then make the first left.
The patient's house is on the far right.
```

Figure G-20: Example of Directions component

G.14 Education Assessment

This component displays the educational assessment information entered in the Health Factors system.

```
------------ EDUCATIONAL ASSESSMENT (max 3 visits) ----------------

Most recent Health Factor recorded.
Learning Preference: DO/PRACTICE (MODERATE)
Readiness to Learn: RECEPTIVE (MODERATE)
Barriers to Learning: SOCIAL STRESSORS (HEAVY/SEVERE)
```

Figure G-21: Example of Education Assessment component

G.15 Elder Care 1 and 2

The Elder Care display component displays information regarding elder care, such as toileting, bathing, dressing, transfers, feeding, continence, finances, cooking, shopping, housework/chores, medications, transportation, change in functional status, and whether the patient is a caregiver.

G.16 Examinations–Most Recent

In the absence of any time or occurrence restrictions, this component displays each of the patient's most recent examinations. The data for this component comes from exams that were recorded on the PCC Encounter Form and typed into the PCC database.

```
------------------ EXAMINATIONS (max 3 visits) --------------------
GENERAL EXAM [CPT: 99395]   08/31/05
BREAST EXAM [CPT: G0101]    11/06/05
HEART EXAM [Dx: V81.2]    08/31/05
PELVIC EXAM [CPT: G0101]    11/06/05
GENERAL DEVELOPMENT EX [Dx: V20.2] 05/19/03
VISION EXAM [Dx: V72.0]    08/06/03
```

Figure G-22: Example of Examinations component

G.17 Eye Care

The Eye Care component displays the patient's last eyeglass prescription typed in the PCC database, as well as eye care measurements and the dates on which they were recorded. In this component, the heading VU means uncorrected vision and VC means corrected vision.

```
--------------------------- EYE CARE -----------------------------

10/10/96 SELLS HOSP
Sphere Cyl Axis Prism Add
R PLANO +8.00 100 .50BI 9.99 Reading only: N Pupil near: 40
L PLANO -9.00 9 .3BU 9.99 Pupil far: 80
Eye Care Measurements
VU VC TONOMETRY
10/10/96 5/120-5/120 50/20-50/20 R18/L20
```

```
11/22/94 20/20-20/20
9/27/93 20/-20/10
7/7/92 20/20-20/20
```

Figure G-23: Example of Eye Care component

G.18 Family Health History

Any family health history that was noted on the PCC Encounter Form and entered into the PCC database displays in this component. The health history is restricted to the V16*, V17*, V18*, and V19* ICD codes. The date that the information was noted on the Encounter Form is shown first, followed by the family health item. The family member and the diagnosis date appear only if recorded as part of the POV narrative on the PCC Encounter Form.

```
------------------ FAMILY HEALTH HISTORY -----------------------

Date Modified Relation/Diagnosis
06/18/08  FATHER (BIOLOGICAL) Status: LIVING
    FHX OF HTN B-S (V17.4); Age at Onset: At age 40-49

06/17/08  MOTHER (BIOLOGICAL) Status: UNKNOWN
    Multiple Birth: UNKNOWN
    FHX OF BREAST CANCER MOTHER (V16.3); Age at Onset: At age 50-59

06/18/08  SON (BIOLOGICAL) oldest Status: LIVING
    Multiple Birth: YES Multiple Birth Type: IDENTICAL TWIN
    Asthma (V17.5); Age at Onset: Before age 20
    FAMILY HX-ALLERGIC DIS (V19.6); Age at Onset: Age Unknown
```

Figure G-24: Example of Family Health History component

G.19 Flowsheets

Flowsheets display selected categories of patient information in a tabular format. The information that can be displayed on a flowsheet consists of all or selected items in the following categories:

- Purpose of Visit
- Measurements
- Medications
- Examinations
- Laboratory Tests
- Patient Education

Because of differences among sites in naming data items, such as laboratory tests and medications, flowsheets must be created locally in order to print in Health Summaries. See the Constructing Flowsheets section in this manual for more information.

Instances of the same data class type might appear more than once for a single visit. Each column can include all items of the specified type or be limited to specific instances for clarity. For example, in the Diabetic Flowsheet below, two items in the Measurement class appear twice: weight and BP.

A flowsheet can be automatically generated by the presence of specified ICD codes in the patient's active problem list. For instance, you might create a diabetic flowsheet at your facility that contains the ICD codes for diabetes as the evoking codes. If a patient had an ICD code for diabetes in the active Problems List, the Diabetic Flowsheet would be printed in that patient's Health Summary. For all other patients, the diabetic flowsheet would not display.

```
------------------------- FLOWSHEETS ------------------------------
DIABETIC FLOWSHEET
   Wt. GLUCOSE HGBA1C TSH  BP  DM EXAMS Pt Ed
   : :   :  :  :  :E  :
-------------------------------------------------------------------
 02/10/04 :0 :   :  :  :100/50 :  :
-------------------------------------------------------------------
 02/09/04 : :   :11.5 :  :  :  :
-------------------------------------------------------------------
 01/05/04 :0 :   :  :  :125/71 :  :
-------------------------------------------------------------------
 12/07/03 :0 :   :  :  :120/67 :  :
```

Figure G-25: Example of Flowsheets component

G.20 Health Factors

The Health Factors component displays information about the patient concerning the following areas:

- Activity Level
- Alcohol/Drug
- Asthma Triggers
- Barriers to Learning
- Confidence in Managing Health Problems
- Diabetes Self-Monitoring
- Health Literacy
- Learning Preference

- Occupation
- Rubella Immunity Status
- TB Status
- Tobacco (Smoking)
- Tobacco (Smokeless–Chewing/Dip)
- Tobacco (Exposure)

Only information that was typed into the database will display in this component of the Health Summary. The Health Factors component can be customized to display either all health factors recorded for a patient or only selected categories; for example, only tobacco use information appears in Figure G-26.

```
---------- HEALTH FACTORS (max 5 visits or 6 years) ---------------

~~ TOBACCO ~~
02/06/07 NON-TOBACCO USER
11/06/06 NON-TOBACCO USER
10/13/06 NON-TOBACCO USER
03/02/06 PREVIOUS SMOKER
   SMOKE FREE HOME
01/03/06 SMOKE FREE HOME
12/15/05 NON-TOBACCO USER
12/08/05 NON-TOBACCO USER
11/15/05 PREVIOUS SMOKER QUANTITY: 0
   SMOKE FREE HOME QUANTITY: 0
```

Figure G-26: Example of Health Factors component

G.21 Health Maintenance Reminders

The HMR system monitors procedures that should be performed periodically for patients depending on their previous diagnoses, age, and sex. These procedures include immunizations, measurements, laboratory tests, examinations, and skin tests. The display includes procedure name, date last performed, and next due date. Refer to the Health Maintenance Reminder section of this manual for more detailed information about HMRs.

```
----- HEALTH MAINTENANCE REMINDERS (max 5 visits or 6 years) -------

      LAST  NEXT

WEIGHT     06/22/07 06/21/08
BLOOD PRESSURE   03/04/06 DUE NOW
PAP SMEAR    01/20/05 Pt had hysterectomy.
```

Figure G-27: Example of HMR component

G.22 History of Minor Surgery

The History of Minor Surgery component displays all of a patient's minor surgeries. Surgeries classified as minor include ICD codes in the 23, 24, and 85 series and code 69.7. The surgery date, provider's name, and a description of the surgery are displayed for this component.

```
-------------- MINOR SURGERY HISTORY (max 5 years) -----------------

08/25/07 SIGMA,JOHN SUTURE HEAD
01/18/06 SIGMA,JOHN SUTURE REMOVAL
```

Figure G-28: Example of Minor Surgery component

G.23 History of Surgery

Past surgical history displays in this component. Excluded are surgeries with ICD codes that display for the History of Minor Surgery component (Series 23, 24, and 85 and Code 69.7). Information regarding the patient's past surgical procedures is documented in the Purpose of Visit section of the PCC Encounter Form by the provider, and is then typed into the database.

```
---------------------- HISTORY OF SURGERY -------------------------

02/03/06     DRAIN/INJECT, JOINT/BURSA
11/16/05     DRAIN/INJECT, JOINT/BURSA
08/08/05     PLACE NEEDLE IN VEIN
04/20/05     DRAIN/INJECT, JOINT/BURSA
```

Figure G-29; Example of History of Srugery component

The date displayed for each procedure refers to the date the procedure was performed and is obtained from the provider's narrative on the PCC Encounter Form. The provider's name displays next followed by the provider's narrative of the surgical procedure. The site where the procedure was performed displays only if that information was included in the provider narrative of the Encounter Form and typed into the database.

G.24 Hospitalization Stays

The Hospitalization Stays component displays the dates of admission and discharge, site of hospitalization, and a provider narrative of the discharge diagnosis for hospitalizations that fall within the time and occurrence constraints. Data for this component are entered into the database from either the CHS Hospital Services Form or the Clinical Record Brief–IHS Inpatient Services Form that is completed when the patient is discharged.

```
--------HOSPITALIZATION STAYS (max 5 visits or 5 years)-------------
```

```
09/08/87 - 09/15/87  DEMO HOSP  ACUTE PYELONEPHRITIS PNEUMONIA
```

Figure G-30: Example of Hospitalization Stays component

G.25 Imaging

The Imaging component will display the following fields:

- mm/dd/yyyy hh:mm
- [Imaging Title]
- Procedure Modifier
- CPT Code
- Interpreting Staff
- Exam Case Number
- Exam Status
- Report Status
- History
- Report
- Impression
- [Provider initials]

```
----------- IMAGING (max 20 visits or 5 years) --------------------


----- IMAGING PROFILE -----
10/21/08 10:41 WRIST 2 VIEWS
 Procedure Modifier: RIGHT
 CPT Code: 73100
FORECAST:

Interpreting Staff: ABLPROVIDER,MERY F
 Exam Case Number: 33
 Exam Status: COMPLETE
 Report Status: VERIFIED

 History:
 no trauma requesting xr

 Report:
 Preliminary:: Negative for fracture or dislocation

 Left wrist: Two views of the left wrist were obtained.
```

```
 Joint spaces are maintained. No fracture, dislocation, or other
abnormality


 Impression:
 1. No abnormality is seen on two view left wrist exam.

 Agree with wet reading

 Diagnostic code #1
```

Figure G-31: Imaging Profile screen

G.26 Immunizations

The Immunizations component displays all immunization data that exist in the PCC database for the patient. Immunizations administered in the outpatient clinic, during a field contact, or in the ER are documented in a PCC Encounter Form and typed into the PCC database. Immunizations given at outside facilities are entered into the database by documentation of the immunization history in the PCC Encounter Form for entry into the database.

As illustrated in the following example, the type of immunization displays first and is followed by the date and site of administration. The immunizations are grouped by type and presented in date sequence with the most recent immunization displaying first. The series number also displays. In order for a series number to display on the health summary, it must have been recorded in the PCC Encounter Form.

```
------------------------- IMMUNIZATIONS ----------------------------
IMMUNIZATION FORECAST:


IMMUNIZATION HISTORY:
  DTP     11/24/05 4 mths Demo Indian Hospital
  DTP     01/19/06 6 mths Demo Indian Hospital
  DTP     03/30/06 8 mths Demo Indian Hospital
  DTP     05/16/07 22 mths Demo Indian Hospital


  OPV     11/24/05 4 mths Demo Indian Hospital
  OPV     01/19/06 6 mths Demo Indian Hospital
  OPV     05/16/07 22 mths Demo Indian Hospital
  MMR     01/24/07 18 mths Demo Indian Hospital
  INFLUENZA   05/16/07 22 mths Demo Indian Hospital
```

Figure G-32: Example of Immunizations component

G.27 In-Hospital Visits

This component displays all of the patient's visits with a service category of In-Hospital. These are visits in which a hospitalized patient was referred to an in-hospital clinic. For instance, the following example shows that the patient was referred to the diabetic clinic and to the physical therapy department during a hospital stay. The date of the encounter displays first, followed by the location of encounter, clinic to which patient was referred, and provider narrative.

```
--------- IN-HOSPITAL VISITS (max 10 visits or 5 years) ------------

02/19/03  SELLS HOSP DIABETIC DM TYPE II HTN
07/01/05  SELLS HOSP PHYSICAL T PHYSICAL THERAPY - WALKING EXERCISES
```

Figure G-33: Example of In-Hospital Visits component

G.28 Infant Feeding Choice Panel

This component displays information about birth weight, birth order, age formula was started, age breast feeding was stopped, and age solids were begun.

```
------------------ INFANT FEEDING CHOICE PANEL ---------------------

BIRTH WEIGHT (kg)
BIRTH ORDER
FORMULA STARTED (age)
BREAST STOPPED (age)
SOLIDS BEGUN (age)
```

Figure G-34: Example of Infant Feeding Choice component

G.29 Insurance Information

This component displays all insurance information that was typed into the Patient Registration database. It is updated as necessary by medical records technicians or the site's social worker.

```
---------------------- INSURANCE INFORMATION -----------------------

INSURANCE  NUMBER  SUFF COV EL DATE  SIG DATE  END DATE
MEDICARE  123456789  A  A  01/01/07  10/14/07
BC/BS   444-55-5555        01/18/06
```

Figure G-35: Example of Insurance Information component

The headings that display in this component are described below.

Heading	Description
INSURANCE	The patient's insurance coverage type

Heading	Description
NUMBER	The group or individual policy number
SUFF	Medicaid suffixes
COV	Type of coverage
EL DATE	The date that the patient became eligible for coverage by the health insurance plan
SIG DATE	The date that the patient signed Medicaid release forms
END DATE	The eligibility renewal date for those types of insurance policies with a stated expiration date necessitating renewal of the patient's eligibility status

G.30 Laboratory Components

Three types of laboratory components are available for the Health Summary:

- Laboratory Data
- Laboratory Data–Most Recent
- Laboratory Data–Most Recent by Date

The link between the Laboratory System and the PCC database allows for retrieval of laboratory results for the laboratory components of the Health Summary. All results entered into the Laboratory System can be printed in the Health Summary.

If you are not using the Laboratory System, laboratory data can be entered into the PCC database via the Lab Log Data Entry option in the PCC Data Entry menu. The data can then be retrieved for inclusion on the Health Summary. It is strongly recommended that laboratory personnel type these results in the PCC database. When using this method, remember that only those laboratory results entered into the database will be displayed in the laboratory components.

If you construct a customized Health Summary, you can limit the test results displayed in either laboratory component by the amount and type of data. For example, you might want to develop a custom summary for the renal clinic that displays only electrolyte, BUN, and creatinine test results. You might also want to restrict the data by length of time or number of occurrences.

G.30.1 Laboratory Data

In the absence of any time or occurrence restrictions, the Laboratory Data component displays all of a patient’s laboratory test results. These results appear below the date on which the laboratory work was performed.

```
---------------- LABORATORY DATA (max 2 years) --------------------

02/08/88  02/15/88  02/22/88
```

```
FBS     310  260  210
HEMATOCRIT   38
```

Figure G-36; Example of Laboratory Data component

G.30.2 Laboratory Data–Most Recent

This laboratory component displays only the most recent occurrence of each different laboratory test. The type of laboratory work that was ordered or performed is listed first, followed by the date, results, units, reference range, and an abbreviation indicating whether the test was accessioned (A), ordered (O), or resulted (R). The results in Figure G-37 were limited to the last two years.

```
---- MOST RECENT LABORATORY DATA (max 10 visits or 5 years) -------

 TEST RESULT DT/TIME VISIT  RESULT UNITS  REF RANGE
BMP     11/15/05
GLUCOSE    11/15/05 74.   mg/dl  65-105
UREA NITROGEN   11/15/05 13.0   mg/dL  7-21
SODIUM     11/15/05 138.   mmol/L  135-145
POTASSIUM    11/15/05  3.9   mmol/L  3.5-5
CHLORIDE    11/15/05 101.   mmol/L  98-107
```

Figure G-37: Example of Laboratory Data - Most Recent component

G.30.3 Laboratory Data – Most Recent by Date

This laboratory component displays only the most recent occurrence of each different laboratory test organized by date. The type of laboratory work that was ordered or performed is listed first, followed by the result date and time, visit date, result, units, reference range, and an abbreviation indicating whether the test was accessioned (A), ordered (O), or resulted (R). The results in the following sample component were limited to the last five years.

```
--- LAB DATA - MOST RECENT BY DATE (max 10 visits or 3 years) -----

 TEST  RESULT DT/TIME VISIT  RESULT  UNITS REF RANGE
PAP SMEAR, CONVENTIO    03/12/08
CREATININE      03/12/08  N   1
CBC        03/11/08
GC DNA PROBE      11/06/06  NEGATIVE
CHLAMYDIA, DNA PROBE    11/06/06  NEGATIVE
```

Figure G-38: Example of Most Recent Laboratory Data component

G.31 Measurement Panels

The Measurement Panel component displays measurement data recorded on the PCC Encounter Form for the patient and fall within the Measurement Panel's data restrictions.

```
---------- MEASUREMENT PANELS (max 5 visits or 5 years) -----------

   HT WT BP  BMI %RW  VU   VC
02/08/07   109/64
02/06/07  122 108/65 20.9 96%
01/18/07   115/66
11/06/06 64 123 101/56 21.1 97%
10/13/06  127 120/88 22.2 103%
05/01/02     20/40-20/30
05/11/99     20/20-20/20
```

Figure G-39: Example of Measurement Panels component

The most common Measurement Panels that display in Health Summaries are the adult or pediatric standard panels that are distributed with the Health Summary package. The display can be presented in standard or metric measurements, depending on which type has been selected for use at the user's facility. The sample shown above is the Adult Standard display. A site can also develop a customized measurement panel for use in health summaries. For more information on Measurement Panels, refer to Section 4.8.2.

The data displayed for this component example are restricted by number of occurrences and by time. Remember that the more restrictive of the two limits dominates. In this case, data are displayed for five visits. Regardless of the limits specified, the most recent measurement of any type requested will always display. A note will print at the bottom of the component if a measurement falls outside of the time limit restrictions. The date of the encounter on which a measurement has been recorded is shown to the left of the measurements.

The standard format for recording BP is utilized: the systolic reading is noted first, followed by the diastolic reading. The headings VU and VC refer to vision acuity measurements. Measurements displaying under the heading VU are for uncorrected vision; VC refers to corrected vision. These headings will always display, whether or not information of this type exists in the database. No headings that indicate the left eye measurement versus the right eye measurement are included. The left eye measurement is presented first, followed by the right eye measurement.

G.31.1 Measurements

The Measurements component displays the same data as the Measurement Panels component, but uses an unformatted, vertical display. The measurement type is indicated first, followed by the date the measurement was taken and the results. Decimals are used to indicate fractions for height, weight, and head circumference. Head circumference displays only on the Pediatric Health Summary.

```
------------- MEASUREMENTS (max 5 visits or 5 years) ---------------

HT 11/06/06 64
  12/15/05  63.386
  11/15/05  63.25
  10/04/04  63.333
  01/27/04  63
WT 02/06/07  122
  11/06/06  122.8
  10/13/06  127
  08/31/06  121
  06/06/06  120.4
BP 02/08/07  109/64
  02/06/07  108/65
  01/18/07  115/66
  11/06/06  101/56
  10/13/06  120/88
```

Figure G-40: Example of Measurements component

G.32 Medication Reconciliation

This component will list the patient's different medications based on status.

The types of medications and data that will be listed are:

- Active: drug name and strength, RX number, number of refills left, directions, and last filled date
- Outside: drug name and strength, directions
- Change HOLD to ACTIVE NOT DISPENSED; display the following: drug name and strength, RX number, number of refills left, directions, reason for hold.
- Suspended: drug name and strength, RX number, number of refills left, directions
- Pending: drug name and strength, number of refills left, directions
- Chronic and Recently Expired: drug name and strength, RX number, number of refills left, directions, last filled date, expired on date
- Recently Discontinued: drug name and strength, RX number, directions, discontinued on date

The headings for medications (ACTIVE, ACTIVE NOT DISPENSED, etc.) will display if there are medications associated with them (for example, if the patient has no ACTIVE NOT DISPENSED medications, nothing will show up for this section, not even the header).

All lines will be 70 characters long.

Expired medications only display if they either (a) become expired within the past 14 days (antibiotics, pan shots in the ER, etc.) or (b) are chronic medications within the last 120 days and the same mediation does not appear with another status on the medication profile.

Discontinued medications only display if they are discontinued within the last 30 days and the same medication does not appear with another status on the medication profile.

```
ACTIVE MEDICATIONS
1. ACETAMINOPHEN 120MG SUP,RTL  Rx #:3463396  Refills left: 1
  Directions: UNWRAP AND INSERT 1 SUPPOSITORY INTO RECTUM EVERY 4 TO
6
     HOURS IF NEEDED FOR PAIN OR FEVER
  Last Filled: 12-03-09
2. COTRIMOXAZOLE SUSP    Rx #:3463383  Refills left: 1
  Directions: SHAKE WELL AND TAKE 2.5ML (1/2 TEASPOONFUL) BY MOUTH
1/DAY
     FOR 30 DAYS TAKE ONCE A DAY
  Last Filled: 11-17-09
```

Figure G-41: An example of a Medication Reconciliation component

G.33 Medication Components

Twelve types of medication components are available for display on the Health Summary:

- Medications–All
- Medications–All W/ #ISS & Alt Name
- Medications–All With Issue History
- Medications–Chronic
- Medications–Chronic & Acute W/Issue
- Medications–Chronic By Name
- Medications–Chronic Excluding D/C’E
- Medications–Controlled Substances
- Medications–Current

- Medications–Current by Name
- Medications–Most Recent by Group
- Medications–Most Recent of Each Medication
- Medications–Most Recent Short Form display

Several of the components display information in the same format, as shown and described here. Time and occurrence display restrictions can be applied to these components. The date indicates the date of the visit at which the medication was dispensed. The name of the medication that was prescribed displays next, followed by the quantity dispensed, the number of days the medication is intended to be taken, and an indication of whether the prescription might have run out or been discontinued. The provider's directions for taking the medication (Sig) appear on the second line. Long Sigs will continue on subsequent lines. If the number of days specified for taking the medication has elapsed, the notation "Ran out" displays for a period of time after the expiration date, unless overridden by a prescription for the same medication. The notation "D/C" indicates that a provider has explicitly discontinued the medication. The term "On Hold" has been changed to "Active But Not Yet Dispensed." All Medication components also include the date of the last medication review, last medication update, and last documented "No Active Medications."

```
- ALL MEDICATIONS (INCLUDES DUPLICATE RX'S) (max 5 visits or 3
years) -

11/28/06 (C) AMOXICILLIN= 500MG CAP #4 (1 days) - Ran out 11/29/06
    TAKE FOUR CAPSULES BY MOUTH 1 HOUR PRIOR TO APPOINTMENT FOR
INFECTION TREATMENT; TAKE UNTIL FINISHED
11/06/06 (C) BREVICON (28) #84 (84 days) -- Ran out 01/29/07
    TAKE 1 TABLET BY MOUTH EVERY DAY FOR BIRTH CONTROL 5
    refills left.
10/13/06  SILVER SULFADIAZINE 1% CREAM (25GM) #25 (7 days) -- Ran
out 10/20/06
    Dispensed at: ER RX
    APPLY TO AFFECTED AREAS DAILY FOR 7 DAYS AS DIRECTED
```

Figure G-42: An example of a Medications component

G.33.1 Medications–All

This component displays a patient's complete medication history for the specified time frame. All instances of prescribed medications are displayed, including current, discontinued, and recently expired medications. Medications with expired prescriptions are displayed for twice the duration of the prescription up to a minimum of 60 days. For example, a medication that was prescribed for 30 days will continue to be displayed for 60 days past its expiration date. Information that is not displayed includes medications that are OTC, starting doses, or acute prescriptions that ran out at least 60 days ago.

G.33.2 Medications–All With Number Issued and Alt Name

This component displays a patient's complete medication history for the specified time frame, as well as the issued and alternative name of the medication.

```
------------ MEDS - ALL WITH # ISSUED (max 3 years) ---------------

MEDICATIONS DISPENSED SINCE Feb 05, 2005
(C) - Chronic Medication, (CRx) - Controlled Drug

11/28/06  (C) AMOXICILLIN= 500MG CAP #4 (1 days)
    TAKE FOUR CAPSULES BY MOUTH 1 HOUR PRIOR TO
    APPOINTMENT FOR INFECTION TREATMENT; TAKE UNTIL
    FINISHED Most recent issue date: 11/28/2006
11/06/06  (C) COTRIMOXAZOLE= DS 800MG/160MG TAB #10 (5 days)
    TAKE 1 TABLET BY MOUTH TWICE A DAY FOR 5 DAYS FOR
    INFECTION TREATMENT; TAKE UNTIL FINISHED
    Most recent issue date: 11/6/2006
    # times prev filled: 2 11/17/2005 3/29/2005
11/06/06  (C) BREVICON (28) #84 (84 days)
    TAKE 1 TABLET BY MOUTH EVERY DAY FOR BIRTH CONTROL
    5 refills left. Most recent issue date: 11/6/2006
```

Figure G-43: An example of Medications - All with Number Issued and Alt Name component

G.33.3 Medications–All With Issue History

This component displays a patient's complete medication history for the specified time frame, as well as the issue history.

```
------ ALL MEDS WITH ISSUE HISTORY (max 5 visits or 3 years) ------

MEDICATIONS DISPENSED SINCE Feb 05, 2005
(C) - Chronic Medication, (CRx) - Controlled Drug

11/28/06  (C) AMOXICILLIN= 500MG CAP #4 (1 days)
   TAKE FOUR CAPSULES BY MOUTH 1 HOUR PRIOR TO APPOINTMENT
    FOR INFECTION TREATMENT; TAKE UNTIL FINISHED
11/06/06  (C) COTRIMOXAZOLE= DS 800MG/160MG TAB #10 (5 days)

    TAKE 1 TABLET BY MOUTH TWICE A DAY FOR 5 DAYS FOR
    INFECTION TREATMENT; TAKE UNTIL FINISHED
    # times prev issued: 2 11/17/2005 3/29/2005
11/06/06  (C) BREVICON (28) #84 (84 days)
    TAKE 1 TABLET BY MOUTH EVERY DAY FOR BIRTH CONTROL
    5 refills left.
```

Figure G-44: An example of Medications - All with Issue History component

G.33.4 Medications–Chronic

This component displays an unduplicated list of current, discontinued, and recently expired medications prescribed for the patient in the time frame specified for the component. Only those medications that the pharmacist has indicated as *chronic* when dispensing will display for this component. The data displayed do not include those medications that are over-the-counter (OTC), starting doses, or acute prescription that ran out at least 60 days ago.

```
------- CHRONIC MEDICATIONS (max 5 visits or 4 years) -------

11/28/06 (C) AMOXICILLIN= 500MG CAP #4 (1 days) -- Ran out 11/29/06
   TAKE FOUR CAPSULES BY MOUTH 1 HOUR PRIOR TO APPOINTMENT
   FOR INFECTION TREATMENT; TAKE UNTIL FINISHED
11/06/06 (C) COTRIMOXAZOLE= DS 800MG/160MG TAB #10 (5 days) – Ran
out 11/11/06 TAKE 1 TABLET BY MOUTH TWICE A DAY FOR 5 DAYS
   FOR INFECTION TREATMENT; TAKE UNTIL FINISHED
11/06/06  (C) BREVICON (28) #84 (84 days) -- Ran out 01/29/07
   TAKE 1 TABLET BY MOUTH EVERY DAY FOR BIRTH CONTROL. 5
   Refills left.
```

Figure G-45: An example of Medications - Chronic component

G.33.5 Medications–Chronic and Acute With Issue History

This component displays a list of chronic and acute medications for the specified time frame with the issue history.

```
------ MEDS - CHRONIC & ACUTE W/ ISSUE HISTORY (max 3 years) ------

Chronic Medications
11/28/06 AMOXICILLIN= 500MG CAP #4 (1 days) (expires 12/28/2006)
   TAKE FOUR CAPSULES BY MOUTH 1 HOUR PRIOR TO APPOINTMENT FOR
INFECTION TREATMENT; TAKE UNTIL FINISHED
11/06/06 COTRIMOXAZOLE= DS 800MG/160MG TAB #10 (5 days)

Acute Medications
10/13/06 SILVER SULFADIAZINE 1% CREAM (25GM) #25 (7 days)
   Dispensed at: ER RX
   APPLY TO AFFECTED AREAS DAILY FOR 7 DAYS AS DIRECTED

04/07/06 ERYTHROMYCIN= 250MG TAB #80 (10 days) (expires 5/6/2006)
   TAKE TWO TABLETS BY MOUTH FOUR TIMES A DAY FOR INFECTION
   TREATMENT; TAKE UNTIL FINISHED
```

Figure G-46: An example of Medications - Chronic and Acute with Issue History component

G.33.6 Medications–Chronic By Name

This component displays a patient's chronic medications by name for a specified time frame.

```
----- CHRONIC MEDICATIONS - SORTED BY DRUG NAME (max 3 years) -----

11/28/06 (C) AMOXICILLIN= 500MG CAP #4 (1 days) -- Ran out 11/29/06
   TAKE FOUR CAPSULES BY MOUTH 1 HOUR PRIOR TO APPOINTMENT FOR
INFECTION TREATMENT; TAKE UNTIL FINISHED
11/06/06 (C) BREVICON (28) #84 (84 days) -- Ran out 01/29/07
   TAKE 1 TABLET BY MOUTH EVERY DAY FOR BIRTH CONTROL 5 refills
left.
11/06/06 (C) COTRIMOXAZOLE= DS 800MG/160MG TAB #10 (5 days) -- Ran
out 11/11/06 TAKE 1 TABLET BY MOUTH TWICE A DAY FOR 5 DAYS FOR
INFECTION TREATMENT; TAKE UNTIL FINISHED
```

Figure G-47: An Example of Medications - Chronic by Name component

G.33.7 Medications–Chronic Excluding D/C'ed

This component displays a patient's chronic medications by name, for a specified time frame, excluding discontinued medications.

```
------- CHRONIC MEDS - EXCL D/C'ed MEDS (max 3 years) -------

11/28/06 (C) AMOXICILLIN= 500MG CAP #4 (1 days) - Ran out 11/29/06
   TAKE FOUR CAPSULES BY MOUTH 1 HOUR PRIOR TO APPOINTMENT FOR
INFECTION TREATMENT; TAKE UNTIL FINISHED
11/06/06 (C) COTRIMOXAZOLE= DS 800MG/160MG TAB #10 (5 days) -- Ran
out 11/11/06 TAKE 1 TABLET BY MOUTH TWICE A DAY FOR 5 DAYS FOR
INFECTION TREATMENT; TAKE UNTIL FINISHED
11/06/06 (C) BREVICON (28) #84 (84 days) -- Ran out 01/29/07
   TAKE 1 TABLET BY MOUTH EVERY DAY FOR BIRTH CONTROL 5 refills
left.
```

Figure G-48: An example of Medications - Chronic Excluding D/C'ed component

G.33.8 Medications–Controlled Substances

The Controlled Substance component displays prescription information for any drug that contains 2, 3, 4, or 5 in the DEA, Special Handling field of the Drug file (50). It displays the medication name, quantity, days' supply, all dispense dates (initial and refills), and provider.

G.33.9 Medications–Current

This component lists the last instance of each different medication prescribed for the patient during the specified time frame. The purpose of this component is to provide an unduplicated list of medications that were dispensed within the specified time frame. It does not include those medications that are over the counter (OTC), starting doses, or acute prescriptions that ran out at least 60 days ago.

G.33.10 Medications–Current by Name

This component lists the last instance of each different medication prescribed for the patient during the specified time frame, by name. The purpose of this component is to provide an unduplicated list of medications dispensed within the specified time frame. It does not include those medications that are OTC, starting doses, or acute prescriptions that ran out at least 60 days ago.

G.33.11 Medications–Most Recent by Group

This component displays medication data in a different format than the other four medication components. As shown in the sample below, the medication name displays first, followed by the last fill date and the quantity dispensed. The Sig appears on the second line of each entry. The data that display in this component are grouped into two sections: Last of Each Chronic Medication and Last of Each Other Medication. The first group, chronic medications, list the last fill of every medication designated as chronic with no restrictions for time and number of occurrences. The second group, other medications, restricts the display data by the time and occurrence parameters that the user specifies when adding this component to the health summary type.

```
--------- MOST RECENT MEDICATIONS BY GROUP (max 3 years) --------

LAST OF EACH CHRONIC MEDICATION (no limit on days) Last fill date
AMOXICILLIN= 500MG CAP     # 4  11/28/06
 Dispensed at:
 Sig: TAKE FOUR CAPSULES BY MOUTH 1 HOUR PRIOR TO APPOINTMENT FOR
 INFECTION TREATMENT; TAKE UNTIL FINISHED
COTRIMOXAZOLE= DS 800MG/160MG TAB   # 10  11/6/06
 Dispensed at:
 Sig: TAKE 1 TABLET BY MOUTH TWICE A DAY FOR 5 DAYS FOR INFECTION
 TREATMENT; TAKE UNTIL FINISHED
BREVICON (28)        # 84  11/6/06
 Dispensed at:
 Sig: TAKE 1 TABLET BY MOUTH EVERY DAY FOR BIRTH CONTROL
MEDROXYPROGESTERONE ACET 150MG/1ML INJ # 1  6/6/06
 Dispensed at:
 Sig: INJECT 150MG INTRAMUSCULAR NOW GIVEN AT WOMENS WELLNESS CLINIC
```

Figure G-49: An example of Medications - Most Recent by Group component

G.33.12 Medications–Most Recent of Each Medication

This component displays the last instance of each different medication that the patient has been prescribed during the specified time frame.

```
----------- MEDS - MOST RECENT OF EACH (max 3 years) -----------

11/28/06 (C) AMOXICILLIN= 500MG CAP #4 (1 days) -- Ran out 11/29/06
```

```
   TAKE FOUR CAPSULES BY MOUTH 1 HOUR PRIOR TO APPOINTMENT FOR
INFECTION TREATMENT; TAKE UNTIL FINISHED
11/06/06 (C) COTRIMOXAZOLE= DS 800MG/160MG TAB #10 (5 days) -- Ran
out 11/11/06 TAKE 1 TABLET BY MOUTH TWICE A DAY FOR 5 DAYS FOR
INFECTION TREATMENT; TAKE UNTIL FINISHED
11/06/06 (C) BREVICON (28) #84 (84 days) -- Ran out 01/29/07
   TAKE 1 TABLET BY MOUTH EVERY DAY FOR BIRTH CONTROL 5 refills
left.
```

Figure G-50: An example of Medications - Most Recent of Each Medication component

G.33.13 Medications–Most Recent Short Form Display

This component follows the same logic as the most recent by group with the exception that the medication display is a short, abbreviated format.

```
----------- MEDS - MOST RECENT SHORT FORM (max 3 years) -----------

LAST OF EACH CHRONIC MEDICATION (no limit on days) Last fill date

AMOXICILLIN= 500MG CAP take four capsules by mouth 1 hour prior to
appointment for infection treatment; take until finished # 4 1
day            11/28/06
 Dispensed at:
COTRIMOXAZOLE= DS 800MG/160MG TAB take 1 tablet by mouth twice a day
for 5 days for infection treatment; take until finished # 10 5 days
11/6/06
 Dispensed at:
```

Figure G-51: An example of Medications - Most Recent Short Form Display component

G.34 Microbiology

This component displays microbiology-related tests, results, and collection and completion date for a specific time frame or occurrence.

```
- MICROBIOLOGY - See Lab for History and Details (max 10 visits or 5
years) -
        RESULT  COLL DATE  COMP DATE

THROAT CULTURE        02/08/07  02/11/07
 Site/Specimen: THROAT
 Collection Sample: SWAB/THROAT

SUSCEPTIBILITY TEST W/ ID      04/04/06
 Site/Specimen: THROAT
 Collection Sample: SWAB/THROAT

THROAT CULTURE        04/04/06  04/06/06

 Site/Specimen: THROAT
 Collection Sample: SWAB/THROAT
```

```
 STAPHYLOCOCCUS AUREUS  Heavy Growth    04/06/06
```

Figure G-52: Example of Microbiology component

G.35 Narrative Text

This component displays narrative text entered by a healthcare provider.

```
----------- NARRATIVE TEXT (max 5 visits or 5 years) --------------

Feb 08, 2007   CHIEF COMPLAINT
 Cold and sore throat since Sunday

Jan 18, 2007   CHIEF COMPLAINT
 Arthritis check up

Aug 31, 2006   CHIEF COMPLAINT
 F/U FROM PREVIOUS VISIT

Apr 04, 2006   CHIEF COMPLAINT
 Possible strep throat <>
```

Figure G-53: Example of the Narrative Text component

G.36 Nutritional Risk Screening Exam

This component displays data from last three Nutritional Risk Screenings (most recent first), Date Completed, Provider (the Nutritional Risk Screening Provider), Risk (low or high; and question topics for which the response is “Yes), and Referral Sent? Yes/No (Y/N). For example:

```
NUTRITIONAL RISK SCREENING EXAMS
-- LAST 3 --

-------- NUTRITIONAL RISK SCREENING EXAMS (LAST 3) -----------------

 DATE  PROVIDER   RISK         RD
                  REFERRAL

 11/12/09 QVPROVIDER,BONNIE HIGH: Weight; Diagnosis; Diff Chew;  Yes
        Other: UNDER 1 YEAR OLD
 11/09/09 QVPROVIDER,BONNIE HIGH: Nut Supp; Weight; Diagnosis;  Yes
        Vom/Diarr
 11/07/09 QVPROVIDER,BONNIE HIGH: Nut Supp; Weight; Diagnosis;  Yes
```

Figure G-54: Example of Nutritional Risk Screening Exam component

G.37 Offspring History

Information about offspring births and deaths can be captured through the data entry process and are displayed in this component of a *female* patient's Health Summary. The decision to enter offspring data and the convention for recording this information for the database are made at the facility level. The child's birth date, name, sex, birth weight, gestational age, and APGAR scores are displayed in a linear fashion. If the child has died, the date and cause of death are displayed in parentheses following the birth information. Any data recorded for perinatal or neonatal complications are also displayed.

```
------------------- OFFSPRING HISTORY ----------------------------

DOB   NAME SEX BWT EGA APGAR DEATH
03/03/83  JOHN M  6.63 40 7/9
12/17/86  JANE F  5.75 36 7/8 (04/15/87:PNEUMONIA)
   PERINATAL COMPLICATION: PRE-ECLAMPSIA HEPATIC FAILURE
   NEONATAL COMPLICATION: MECONIUM ASP. SEPSIS
```

Figure G-55: Example of the Offspring History component

G.38 Outpatient Data

There are three components related to outpatient or field visits:

- Outpatient/Field Visits
- Outpatient Visits–Excluding CHR
- Outpatient Visits–Screened

G.39 Outpatient Field Visits

The Outpatient/Field Visits component displays visits (encounters) entered into the PCC database. These data are extracted from the information recorded in the POV section on the PCC Encounter Form. Although the component heading states that the data displayed are outpatient or field visits, data in this component can also include visits in the following service categories:

- Ambulatory
- Nursing Home
- Day Surgery
- Chart Review
- Observation
- Telecommunications

The date the encounter took place displays first, followed by the location of the encounter. The clinic location might also be included if the site has elected to have it displayed. The provider's narrative displays in the last column. This narrative is either the provider's verbatim narrative or an ICD narrative with or without the ICD code, depending on which type of display has been chosen by the site. The standard PCC distribution displays the provider narrative only. During data entry, the narrative is coded to an ICD-9 code and the code is retained for retrieval purposes, even though only the provider narrative can be displayed. See Section 3.6 for details on selecting the form of the data to display in this component.

```
------- OUTPATIENT/FIELD VISITS (max 5 visits or 5 years) ---------

07/26/07 DEMO HO  ER  CONTACT DERMATITIS
02/05/07 DEMO HO  W. I. C. WIC-RECERT
```

Figure G-56: Example of the Outpatient/Field Visits component

G.40 Outpatient Visits (Excluding CHR)

This component list the outpatient visits, excluding CHR visits, for a specific time frame.

```
--- OUTPATIENT/FIELD VISITS (Excludes CHR visits) (max 5 years) ---

02/04/08 DEMO HO  GEN  FLU SYMPTOMS
02/02/08 DEMO HO    <purpose of visit not yet entered>
06/04/07 DEMO HO  DENTAL 6AP(12-13-07)GH
02/08/07 DEMO HO  GEN  Acute Pharyngitis
02/06/07 DEMO HO  ER  URI
        HEART MURMUR
```

Figure G-57: Example of the Outpaitent Visits component

G.41 Outpatient Visits (Screened)

The Outpatient Visits (Screened) component displays exactly the same information as the Outpatient/Field Visits component described above, except that it allows the user to screen out certain visits from the component by provider class or clinic. For example, the user could choose to exclude all visits to the Employee Health clinic.

```
-- OUTPATIENT/FIELD VISITS (SCREENED) (max 5 visits or 5 years) --

07/26/07 DEMO HO  ER  CONTACT DERMATITIS
02/05/07 DEMO HO  W. I. C. WIC-RECERT
11/22/06 DEMO HO  ER  R OM
        R OTORRHEA
11/17/06 DEMO HO  ENT  HEARING LOSS
        CERUMEN IMPACTION
        SPEECH DELAY
```

```
        FHX HEARING LOSS - MOTHER R EAR
11/03/06 DEMO HO  GEN  URI
        ALLERGIES RHINNITIS
```

Figure G-58: Example of the Outpatient/Field Vists (Screened) component

G.42 Patient Education

There are three components related to patient education:

- Patient Education
- Patient Education–Most Recent
- Patient Education–Most Recent by Topic

G.42.1 Patient Education Component

This component displays all instances of patient education provided within the date or visit constraints specified. The development of a standardized set of patient education topics and their entry into the PCC is a local option. The types of education provided must be determined by each site and then typed into the Education Topic file before any data will display in this component.

The types of information that can be displayed are illustrated in Figure G-59. The date of the patient encounter, the site, the type of patient education provided, and if supplied, the patient's level of understanding of the education provided displays on a single line.

```
--------------- PATIENT EDUCATION (max 5 years) ---------------

02/02/08 DEMO HO  DM-FC  DM-FOOT CARE
         GOOD UNDERSTANDING
         Behavior Code: GOAL SET
         Objectives Met: MONITOR FEET
06/04/07 DEMO HO  ADA: 1330 - PREVENTIVE PLAN AND INSTRUCTION
02/06/07 DEMO HO  DC-FU  DC-FOLLOW-UP
         GOOD UNDERSTANDING
```

Figure G-59: Example of the Patient Education component

G.42.2 Patient Education–Most Recent Component

This component displays the most recent instance of every type of patient education provided.

```
---------- MOST RECENT PATIENT EDUCATION (max 5 years) ----------

02/02/08 DEMO HO  DM-FC  DM-FOOT CARE
         GOOD UNDERSTANDING
```

```
      Behavior Code: GOAL SET  Objectives Met: MONITOR FEET
06/04/07 DEMO HO  ADA: 1330 - PREVENTIVE PLAN AND INSTRUCTION
02/06/07 DEMO HO  DC-FU  DC-FOLLOW-UP
         GOOD UNDERSTANDING
```

Figure G-60: Example of the Most Recent Patient Education component

G.42.3 Patient Education–Most Recent by Topic Component

This component organizes by topic the most recent instance of every type of patient education provided.

```
---------- MOST RECENT PATIENT EDUCATION (max 5 years) ----------

02/02/08 DEMO HO  DM-FC  DM-FOOT CARE
         GOOD UNDERSTANDING
      Behavior Code: GOAL SET  Objectives Met: MONITOR FEET
06/04/07 DEMO HO  ADA: 1330 - PREVENTIVE PLAN AND INSTRUCTION
02/06/07 DEMO HO  DC-FU  DC-FOLLOW-UP
         GOOD UNDERSTANDINGTANDING   10/08/04 CIHA W W CTR
  URIN TRACT INFECTION NOS
```

Figure G-61: Example of the Patient Education - Most Recent by Topic component

G.43 Patient Goals

This component displays active and inactive goals patient goals. Goals with a status of active or maintaining are considered active goals. Goals stopped or met in the past twelve months are considered inactive goals.

```
       ---------------------PATIENT GOALS ---------------

ACTIVE GOALS (ALL ACTIVE AND MAINTAINING GOALS)

GOAL ID:   CI7      Status: MAINTAINING GOAL
         STOP DRINKING
         Start: 11/01/11   Follow up: 11/24/11   Modified: 12/08/11
         Type: ALCOHOL OR OTHER DRUGS
         Goal Name: STOP DRINKING
         Reason: ALCOHOLIC
         Provider: Test, Provider

INACTIVE GOALS (ALL GOALS STOPPED OR MET IN PAST 12 MONTHS)

GOAL ID:   CI2      Status: GOAL MET
         REDUCE STRESS
         Start: 02/04/11   Follow up: 02/24/11   Modified: 06/23/11
         Type: STRESS AND COPING  PHYSICAL ACTIVITY
         Goal Name: REDUCE STRESS
         Reason: VERY STRESSED AND CRYING ALL THE TIME
         Provider: Test, Provider
   CI Step#1          Status: ACTIVE
         START MEDITATING
         Start: 01/27/11   Follow Up: 02/24/11
         Type: STRESS AND COPING   Provider: Test, Provider
```

Figure G-62: Example of the Patient Goals component

G.44 Patient Wellness Handout

This component displays the patient's PWH. Refer to Section 6.0 for more detailed information.

G.45 Patient Wellness Handout Tally

This component displays the following information about each PWH type given to the patient: type of PWH given to patient; total number of that specific type given to the patient, and the dates that type was given to the patient. Refer to Section 4.15 of this manual for more detailed information.

```
---- PATIENT WELLNESS HANDOUT TALLY (max 10 visits or 3 years) ----
 PATIENT WELLNESS HANDOUT TYPE # given Dates Last 4 Given to Patient
-------------------------------------------------------------------
 ADULT REGULAR     3  8/01/08 9/05/08 10/08/0
```

Figure G-63: Example of the Patient Wellness Handout Tally component

G.46 Personal Medical History

Past medical information not included in the patient's active and inactive problem list but warrants documentation on the health summary displays in this component. Personal medical history is retrieved from data that are recorded in the Purpose of Visit section of the PCC Encounter Form and entered into the PCC database. The date the information was entered, the historical information, and the onset date are displayed.

```
------------ PERSONAL MEDICAL HISTORY (max 3 years) ---------------

10/02/05 HX HTN
10/23/06 HYSTERECTOMY (onset: 01/05)
```

Figure G-64: Example of the Personal Medical History component

G.47 Prenatal

This component lists the data pertaining to abdominal girt, cervix dilation, edema measurement, expected date of confinement, effacement, fundal height, fetal heart tones, last menstrual period, presentation (pregnancy), and station (pregnancy).

G.48 Problem List Data

Two Problem List components are available for inclusion in the Health Summary:

- Problems–Active
- Problems–Inactive

No time or visit restrictions can be placed on these components. Instead, the information displayed is controlled by provider instructions that are recorded in the PCC Encounter Form. By using the POV section of the form, the provider can maintain the active problem list by adding, updating, modifying, or appending data. Each data item that is printed in these components is described here. Both Problem-related components include the date of the last problem list review, problem list update, and date of the last documented "No Active Problems."

G.49 Identification Number and Problem

Each problem is identified by a number that displays in the first column of the component. This number is assigned by the computer when the problem is entered into the database for the first time. The identification number is formed from an abbreviation of the site name at which the problem was entered and a sequence number specific to the individual patient at that facility. No two problems will ever have the same number, although two different numbers can have the same problem narrative. The date on which the problem was initially entered, and the date of the most recent modification to the problem will display after the problem identification number.

In the Active Problems example shown below, the problem Diabetes Mellitus is identified as number SX1. This problem was entered into the database at the San Xavier Health Center (SX) and was the first problem typed at that facility for the patient. Problem SX1 will always be Diabetes Mellitus. If Diabetes Mellitus were entered for this patient at a different facility (e.g., Sells) the problem would be assigned a number that identifies that facility and the sequence in which the problem was entered (e.g., SE3 Diabetes Mellitus). The dates shown in the two columns to the right of the problem number indicate when the problem was first entered and when it was last modified.

G.50 Problem Narrative

The problem narrative displays in the column on the right side of the component. The printed narrative appears in one of the following formats: (1) verbatim, (2) a long or short standard narrative based on ICD code, or (3) a combination of provider narrative and ICD narrative. The type of narrative displayed is designated locally by each site. The standard PCC component displays the provider narrative only; however, it can be modified by each site as needed.

G.51 Problem Notes

The active problems narrative can be enhanced by appending additional information in the form of notes. The second line in the Active Problems component sample (identification number SX1SX1) is a problem note. In this case, it is a note for Problem SX1, Diabetes Mellitus. Identification numbers of notes differ from problem numbers in that they have more characters and identify not only the note, but the problem to which they are appended. The first site prefix and sequence number (e.g., SX1) reference the problem to which the note is appended. The second site prefix and sequence number reference the site and sequence of the note's addition to the problem. Although this number represents the combination of two numbers, it should be thought of as a single number that identifies the note.

Notes are displayed just below the narrative of the corresponding problem and are indented to highlight them and set them apart from problem narratives. Notes have several functions:

- To communicate treatment plans associated with the problem; for example, NEEDS FBS MONTHLY or STARTED INH 4/1/95
- To provide additional information about the problem that is not contained in the limited problem narrative, such as encounter date of the initial problem work-up or the precipitating factors that led to a disability

If the provider who is modifying the patient's problem list uses a special numbering convention on the PCC Encounter Form, problems that share the same basic etiology can be displayed in diagnostically related groups in the Health Summary. These related diagnoses are grouped together under the primary diagnosis and their relationship to the primary diagnosis is indicated by the format of their identification numbers. In this example, the third and fourth lines (identification numbers SX1.1 and SX1.2) show the special numbering sequence the provider has indicated in the PCC Encounter Form. The primary diagnosis identification number (e.g., SX1) displays first, followed by a decimal point and a separate number that identifies the related problem (e.g., SX1.1). This number, similar to the note identification number, is the complete identification number of the related diagnosis.

G.51.1 Active Problems

This component provides a comprehensive listing of the patient's active medical, social, and psychological problems. Active problems are those that currently affect the patient's health or, if presently quiescent, are at high risk for recurrence.

```
----------------------- ACTIVE PROBLEMS --------------------------

    ENT.  MODIFIED
SX1   05/80  07/06/93 DIABETES MELLITUS (diagnosed 06/07/75)
SX1SX1     07/06/91 - DIABINESE 250 MG
SX1.1  07/91  08/30/95 NEUROPATHY
SX1.2  08/91  08/30/95 PERIODONTAL DISEASE
SX2   09/91  09/17/95 PENICILLIN ALLERGY, ANAPHYLAXIS
SX5   10/91  10/27/93 DYSFUNCTIONAL UTERINE BLEEDING
SX8   09/92  01/23/94 HYPERTENSION
```

Figure G-65: Example of the Active Problems component

G.51.2 Inactive Problems

The Inactive Problems component displays a patient's inactive medical, social, and psychological problems. Inactive problems are those that have been resolved but might recur in the future. These recurring problems may place the patient at increased risk (e.g., asbestos exposure) or leave residual physical findings. Note that conditions resolved by surgery are displayed in the History of Surgery component.

```
----------------------- INACTIVE PROBLEMS -------------------------

   ENT.  MODIFIED
SX6   08/14/90 06/16/95 PYELONEPHRITIS
SX7   06/29/95 09/23/95 NX LEFT HIP FRACTURE
```

Figure G- 66: Example of the Inactive Problems component

G.52 Public Health Nursing Visits

The Public Health Nursing (PHN) component displays all visits for which a public health nurse was the primary provider. This component display is very similar to the Outpatient Visits component. The following additional data items are displayed in this component:

- Level of intervention
- Nsg Dx
- Type of decision making
- Short-term goals
- Psycho/social/environmental factors
- Long-term goals

These data items are captured in the Public Health Nursing PCC form. If typed into the PCC database, they will display in the Health Summary.

```
----- PUBLIC HEALTH NURSING VISITS (max 5 visits or 5 years) -------

12/15/05 DEMO PHN  MCC F/U
11/10/04 DEMO PHN  FLU VACCINE
```

Figure G-67: Example of the PHN component

G.53 Radiology Data

There are two components related to radiology: (1) Radiology Studies–Most Recent and (2) Radiology–Exams.

G.53.1 Radiology Studies–Most Recent

In the absence of any time or occurrence restrictions, this component displays the most recent result of each radiology study taken for the patient. The PCC linkage with the radiology system provides the data for this component.

The type of radiology study is listed first, followed by the date it was performed in parentheses. The results and the clinical impression also display in the component.

```
--- MOST RECENT RADIOLOGY STUDIES (max 10 visits or 10 years) ------

CHEST 2 VIEWS PA&LAT (09/08/03)
 IMPRESSION: No evidence of acute cardiopulmonary disease.
```

Figure G-68: Example of the Radiology - Most Recent component

G.53.2 Radiology–Exams

In the absence of any time or occurrence restrictions, this component displays the most recent result for each radiology exam for the patient. The PCC linkage with the radiology system provides the data for this component.

The date of the radiology exam is listed first, followed by the description and additional comments. The results and the clinical impression also display in the component.

```
---------- RADIOLOGY EXAMS (max 5 visits or 10 years) -------------

02/21/01 CHEST 2 VIEWS PA&LAT (2/21/2001)


   IMPRESSION: Pectus excavatum. No evidence of pneumonia.

12/20/05 SPINE CERVICAL MIN 4 VIEWS (12/20/2005)
   IMPRESSION: CONCLUSION: Minimal degenerative changes as
   above. Dictated by:
   John Sigma, M.D. on 12/20/2005 at 11:59 Approved by: John
   Sigma, M.D. on 12/20/2005 at 11:59 cc:
```

Figure G-69: Example of the Radiology Exams component

G.54 Referred Care

The Referred Care component lists the patient's referral record within the date and occurrence restrictions specified. This component is available only at sites using the Referred Care Information System (RCIS) with the PCC link enabled. Each time a patient is referred to an outside facility for care, the referral information is entered into the RCIS. The data items included in the Referred Care component of the Health Summary include:

- Beginning date of service
- Whether the visit was for inpatient or outpatient services
- Referral status
- Initials of the referring provider
- Facility to which the patient was referred
- Diagnostic category

- Service category

```
------------------ REFERRED CARE (max 1 year) -------------------

BEGIN DOS: 03/06/96  OUTPATIENT  STATUS: ACTIVE
REFERRED BY: EDE   REFERRED TO: UNIVERSITY MEDICAL CENTER
DIAGNOSTIC CATEGORY: OBSTETRICAL CARE
CPT SERVICE CATEGORY: OPERATIONS/SURGERY

BEGIN DOS: 02/05/96  OUTPATIENT  STATUS: CLOSED - COMPLETED
REFERRED BY: EDE   REFERRED TO: TMC FAMILY MEDICAL CENTER
DIAGNOSTIC CATEGORY: RESPIRATORY DISORDERS
CPT CATEGORY: EVALUATION AND/OR MANAGEMENT
```

Figure G-70: Example of the Referred Care component

G.55 Refusals/Declined Services

This component lists the patient's refusals for service in the specified time frame.

```
--------- PATIENT REFUSALS FOR SERVICE (max 10 years) -------------

Nov 1, 2006 INTIMATE PARTNER VIOLENCE (EXAM)
  Refusal Type: UNABLE TO SCREEN

Sep 1, 2006 INTIMATE PARTNER VIOLENCE (EXAM)
  Refusal Type: UNABLE TO SCREEN
```

Figure G-71: Example of the Patient Refusals for Service component

G.56 Refusals/Declined Services -Most Recent of Each

This component lists the patient's most recent refusals for service in the specified time frame for a particular type.

```
PATIENT REFUSALS FOR SERVICE - MOST RECENT OF EACH (max 10 years)

INTIMATE PARTNER VIOLENCE   (UNABLE TO SCREEN)   11/1/2006
```

Figure G-72: Example of the Patient Refusals for Service - Most Recent of Each component

G.57 Reproductive History – Brief

This component will display only if data regarding the patient's gravidity, parity, number of children, history of abortion, last menstrual period (LMP), or contraceptive method have been typed in the PCC database. If multiple EDD method data is entered, the latest information displays. If a Definitive EDD date exists, only the Definitive EDD data displays. The Reproductive History component will display only the information stored in the database; therefore, an incomplete history might display. The date each data item was obtained is shown as an aid in reviewing the patient's chart for the timeliness of the data. If there is an item for which no data has been recorded, the notation "Not Recorded" follows the subheading. Subsequent reproductive information noted by the provider in the PCC Encounter Form replaces the previous data.

```
--------------------- REPRODUCTIVE HISTORY ------------------------
Reproductive History:
 Total # of Pregnancies 5; Full Term 3 ; Premature 0; Abortions,
Induced 0; Abortions, Spontaneous 0; Multiple Births 3; Living
Children 1
LMP: 06/01/07 (obtained 10/14/08)
CONTRACEPTION: ORAL CONTRACEPTIVES (obtained 10/14/08)
*** NOTE: EDD 03/12/08 (obtained 10/14/08) -- OUTDATED!
```

Figure G-73: Example of the Reproductive History component

G.58 Reproductive History – All EDD

This component displays the information included in the Reproductive History – Brief component and multiple EDD dates and methods when entered.

G.59 Scheduled Encounter Data

This component obtains data from the Clinic Scheduling package. No information will display if the package is not used at your facility or if no scheduling data has been recorded for the patient.

Past appointments are displayed according to the date and visit count constraints. All future (pending) appointments are displayed with the length of each appointment and any special comments recorded. The user can display scheduled encounters with chart or scheduled encounters without chart required.

G.60 Skin Test Data

Two types of Skin Test components may appear in the Health Summary: (1) All or (2) Last 3 of Each. Skin test information is typed into the database from the PCC Encounter Form. Each of these components displays the type of skin test administered. If multiple skin tests of the same type were given, they are grouped together and displayed in date sequence, with the most recent test appearing first. The date the skin test was read is shown next, followed by the results of the test. The facility at which the test was administered is shown to the right of the test result. A sample component is shown in Figure G-73.

```
---------------------- SKIN TESTS ---------------------------------
PPD 08/01/91 unrep DEMO HOSP
COCCI 04/25/91 0 mm DEMO HOSP
```

Figure G-74: Example of the Skin Tests component

G.60.1 Skin Tests–All

This component displays all skin tests administered to the patient and the test results.

G.60.2 Skin Tests–Last 3 of Each

This component limits the data displayed to only the last three instances of each skin test type administered.

G.61 Supplements

Supplements are specially written additions to the Health Summary that may be printed each time a Health Summary is generated. There are several supplements available:

- Asthma Patient Care Summary
- Anticoagulation
- Chronic Med Reorder Doc-Date
- Chronic Med Reorder Doc-Name
- Chronic Med Reorder Short Form
- Diabetic Care Summary
- Medication Reorder Doc By Date
- Medication Reorder Doc By Name
- Pre-Diabetes Care Summary

Refer to Section 4.8.10 for more information about Supplements.

Below is an example of the Asthma Patient Care Summary supplement:

```
ASTHMA PATIENT CARE SUMMARY     Report Date: Oct 08, 2008
SIGMA,ANGELA      HRN: 111111
DOB: Jul 01, 1987 Age: 21 F  Asthma Diagnostic Tag: Accepted

DESIGNATED PRIMARY PROVIDER: FPROVIDER,CLAUDINE Y
CASE MANAGER: GAMMAAA,AMANDA D

Problem List:
 DH2 NONE (493.90)
  Asthma Severity: 3-MODERATE PERSISTENT
  Date of Onset: None Documented
  Date Last Updated: AUG 22, 2008

Most Recent Control: Oct 07, 2008 NOT WELL CONTROLLED

Asthma-Related FAMILY HEALTH HISTORY:
Date Last Mod Relation/Status/Diagnosis
10/07/08  NATURAL BROTHER Status: LIVING
    Multiple Birth: NO
    FAMILY HX-ASTHMA (V17.5); Age at Onset: Before age 20
10/02/08  COUSIN (FEMALE) Status: LIVING
    Multiple Birth: NO
    NONE (V17.5); Age at Onset: None
Personal Best Peak Flow 500 liters/minute on Apr 18, 2008

Peak Flow Zones Green (80-100%) 400-500 liters/minute
     Yellow (50-79%) 250-395 liters/minute
     Red (< 50%)  < 250 liters/minute

Date of Last Asthma Action Plan: NEEDS TO BE REVIEWED

Triggers: No Triggers identified.

Last Recorded TOBACCO Screening: HF: CURRENT SMOKER Oct 07, 2008

Last 5 Visits w/LUNG FUNCTION Measurements
 DATE   FEV1/FVC  Highest Visit Peak Flow FEF 25-75
-----------------------------------------------------------------
 Apr 18, 2008  5/5 (1.00) 100
 Mar 06, 2008  50
 Mar 06, 2008  1000

Asthma Symptom-Free Days:
 Visit Date  Symptom-Free Days
-------------------------------------------------

 Apr 18, 2008  3

Asthma Work/School Days Missed:
 Visit Date  Work/School Days Missed
-------------------------------------------------
 Apr 18, 2008  3
```

```
Number of Reliever Fills in past 6 months: 0

Number of Controller Fills in past 6 months: 0

 -------RELIEVER MEDICATIONS (FILLED IN THE PAST 6 MONTHS------
OUTPUT BROWSER   Oct 08, 2008 10:57:42  Page: 5 of 5

 -------CONTROLLER MEDICATIONS (FILLED IN THE PAST 6 MONTHS------

Last of each ASTHMA Patient Education done:
 TOPIC       LEVEL OF UNDERSTANDING DATE
-------------------------------------------------------------------
ASM-MANAGEMENT PLAN     GOOD    Aug 26, 2008
```

Figure G-75: Example of Asthma Patient Care Summary supplement

```
MEDICATION REORDER DOCUMENT   Date: Oct 08, 2008 Page: 1
Patient: SIGMA,ANGELA HRN: 111111

LATEST OF EACH CHRONIC MEDICATION DISPENSED IN THE PAST YEAR

11/28/06 AMOXICILLIN= 500MG CAP -- Ran out 11/29/06
   QTY: 4 (1 days) ENSLEY,HAROLD B - DENTAL
   TAKE FOUR CAPSULES BY MOUTH 1 HOUR PRIOR TO APPOINTMENT FOR
   INFECTION TREATMENT; TAKE UNTIL FINISHED
   RENEW __________ DC __________

11/06/06 BREVICON (28) -- Ran out 01/29/07
   QTY: 84 (84 days) BARNETT,D L - PHARMACY
   TAKE 1 TABLET BY MOUTH EVERY DAY FOR BIRTH CONTROL
   5 refills left.

   RENEW __________ DC __________

11/06/06 COTRIMOXAZOLE= DS 800MG/160MG TAB -- Ran out 11/11/06
  QTY: 10 (5 days) BARNETT,D L - PHARMACY
  TAKE 1 TABLET BY MOUTH TWICE A DAY FOR 5 DAYS FOR INFECTION
  TREATMENT; TAKE UNTIL FINISHED
  Previously filled: 11/17/05 03/29/05 10/08/04

  RENEW __________ DC __________



DISPENSE UNTIL NEXT SCHEDULED EVALUATION: ________

SIGNATURE: ____________________________________ DATE: ________________
```

Figure G-76: Example of the Chronic Medication Reorder Doc Date supplement

```
MEDICATION REORDER DOCUMENT   Date: Oct 08, 2008 Page: 1

Patient: SIGMA,ANGELA HRN: 111111
```

```
LATEST OF EACH CHRONIC MEDICATION DISPENSED IN THE PAST YEAR

11/28/06 AMOXICILLIN= 500MG CAP -- Ran out 11/29/06
   QTY: 4 (1 days) ENSLEY,HAROLD B - DENTAL
   TAKE FOUR CAPSULES BY MOUTH 1 HOUR PRIOR TO APPOINTMENT FOR
   INFECTION TREATMENT; TAKE UNTIL FINISHED
   RENEW __________ DC __________

11/06/06 BREVICON (28) -- Ran out 01/29/07
   QTY: 84 (84 days) BARNETT,D L - PHARMACY
   TAKE 1 TABLET BY MOUTH EVERY DAY FOR BIRTH CONTROL
   5 refills left.

   RENEW __________ DC __________

11/06/06 COTRIMOXAZOLE= DS 800MG/160MG TAB -- Ran out 11/11/06
   QTY: 10 (5 days) BARNETT,D L - PHARMACY
   TAKE 1 TABLET BY MOUTH TWICE A DAY FOR 5 DAYS FOR INFECTION
   TREATMENT; TAKE UNTIL FINISHED
   Previously filled: 11/17/05 03/29/05 10/08/04

   RENEW __________ DC __________

DISPENSE UNTIL NEXT SCHEDULED EVALUATION: ________
SIGNATURE: ________________________________ DATE: ________________
```

Figure G-77: Example of Chronic Medication Reorder Doc-Name supplement

```
MEDICATION REORDER DOCUMENT   Date: Oct 08, 2008 Page: 1

Patient: SIGMA,ANGELA HRN: 111111

LATEST OF EACH CHRONIC MEDICATION DISPENSED SINCE Oct 09, 2005

11/28/06 AMOXICILLIN= 500MG CAP
   QTY: 4 (1 days) ENSLEY,HAROLD B – DENTAL

  TAKE FOUR CAPSULES BY MOUTH 1 HOUR PRIOR TO APPOINTMENT FOR
  INFECTION TREATMENT; TAKE UNTIL FINISHED
  Rx # 2623067

11/06/06 BREVICON (28)
   QTY: 84 (84 days) BARNETT,D L - PHARMACY
   TAKE 1 TABLET BY MOUTH EVERY DAY FOR BIRTH CONTROL
   Rx # 2618727    5 refills remaining.

11/06/06 COTRIMOXAZOLE= DS 800MG/160MG TAB
   QTY: 10 (5 days) BARNETT,D L - PHARMACY
   TAKE 1 TABLET BY MOUTH TWICE A DAY FOR 5 DAYS FOR INFECTION

   TREATMENT; TAKE UNTIL FINISHED
   Rx # 2618726

Refill all meds ____ times, or ____ until next scheduled evaluation
```

```
SIGNATURE: _____ DATE: _____
```

Figure G-78: Example of Chronic Medication Reorder Short Form Supplement

```
DIABETES PATIENT CARE SUMMARY   Report Date: Oct 08, 2008
Patient Name: SIGMA,ANGELA HRN: 111111

Age: 21  Sex: F   Date of DM Onset:
Dob: Jul 01, 1987   DM Problem #: DH3
**NOT ON DIABETES REGISTER** Primary Care Provider:
FPROVIDER,CLAUDINE Y
Last Height: 64 inches  Nov 06, 2006
Last Weight: 254 lbs   Mar 12, 2008 BMI: 43.5
Last Waist Circumference: 35 Mar 06, 2008
Tobacco Use: CURRENT SMOKER Oct 07, 2008
HTN Diagnosed: No
ON ACE Inhibitor/ARB in past 6 months: No
Aspirin Use/Anti-platelet (in past yr): No
Last 3 BP: 109/64 Feb 08, 2007 Is Depression on the Problem List?
   115/66 Jan 18, 2007  Yes - Problem List 311.
   101/56 Nov 06, 2006

In past 12 months:
Diabetic Foot Exam: No
Diabetic Eye Exam: No Oct 10, 2006

Dental Exam:   Yes Mar 06, 2008 (Dental Exam 30 recorded)
(Females Only)
Last Pap Smear documented in PCC/WH: Mar 12, 2008

WH Cervical TX Need:
Mammogram: ^

SMBG: No Evidence in the past year
DM Education Provided (in past yr):
 Last Dietitian Visit:  Apr 18, 1989 WIC - ROUTINE HEALTH CARE
 DM-FOOT CARE    Feb 02, 2008
 NUTRITION (SESSION 1: IN Feb 11, 2008

Immunizations:
Flu vaccine since August 1st: Yes Aug 26, 2008
Pneumovax ever:    No
Td in past 10 yrs:    No May 19, 1992
Last Documented PPD:  0 Oct 07, 2004
Last TB Status Health Factor: Last CHEST X-RAY: Feb 21, 2001
EKG:       Mar 12, 2008   NORMAL

Laboratory Results (most recent):
HbA1c:    NORMAL   Oct 07, 2008 HEMOGLOBIN A1C
Next most recent HbA1c:
Nephropathy Assessment
 Urine Protein:   TRACE   Nov 15, 2005 URINE PROTEIN, SCREEN
 Microalbuminuria:
 A/C Ratio:
 Creatinine:    N    Mar 12, 2008 CREATININE
```

```
 Estimated GFR:   116   Nov 15, 2005
Total Cholesterol:  183.   Nov 15, 2005 CHOLESTEROL SCREEN
 LDL Cholesterol:  112.   Nov 15, 2005 LDL


 HDL Cholesterol:  51.   Nov 15, 2005 HDL (CHOLESTEROL)
 Triglycerides:   102.   Nov 15, 2005 SCREEN, TRIGLYCERIDES
```

Figure G-79: Example of Diabetic Care Summary supplement

```
MEDICATION REORDER DOCUMENT    Date: Oct 08, 2008 Page: 1
Patient: SIGMA,ANGELA HRN: 111111

LATEST OF EACH NON-CHRONIC MEDICATION DISPENSED SINCE Oct 09, 2005

10/13/06 SILVER SULFADIAZINE 1% CREAM (25GM) -- Ran out 10/20/06
   QTY: 25 (7 days)
   APPLY TO AFFECTED AREAS DAILY FOR 7 DAYS AS DIRECTED
   Dispensed at: ER RX

   RENEW __________ DC __________

04/07/06 ERYTHROMYCIN= 250MG TAB -- Ran out 04/17/06
   QTY: 80 (10 days) MCANICH,KATHRYN M KMH - PHARMACY
   TAKE TWO TABLETS BY MOUTH FOUR TIMES A DAY FOR INFECTION
TREATMENT; TAKE UNTIL FINISHED

   RENEW __________ DC __________

DISPENSE UNTIL NEXT SCHEDULED EVALUATION: ________

SIGNATURE: ___________________________________ DATE: _________________
```

Figure G-80: Example of Medication Reorder Doc by Date supplement

```
MEDICATION REORDER DOCUMENT   Date: Oct 08, 2008 Page: 1
Patient: SIGMA,ANGELA HRN: 111111

LAST OF EACH NON-CHRONIC MEDICATION DISPENSED SINCE Oct 09, 2005

04/07/06 ERYTHROMYCIN= 250MG TAB -- Ran out 04/17/06
   QTY: 80 (10 days) MCANICH,KATHRYN M KMH - PHARMACY
   TAKE TWO TABLETS BY MOUTH FOUR TIMES A DAY FOR INFECTION
TREATMENT; TAKE UNTIL FINISHED

   RENEW __________ DC __________

10/13/06 SILVER SULFADIAZINE 1% CREAM (25GM) -- Ran out 10/20/06
   QTY: 25 (7 days)
   APPLY TO AFFECTED AREAS DAILY FOR 7 DAYS AS DIRECTED
   Dispensed at: ER RX

   RENEW __________ DC __________
```

```
12/22/05 SULINDAC= 150MG TAB -- Ran out 01/05/06
   QTY: 28 (14 days) MCANICH,KATHRYN M KMH - GENERAL
   TAKE ONE TABLET BY MOUTH TWICE A DAY FOR PAIN; TAKE WITH FOOD OR
MILK

   RENEW __________ DC __________

DISPENSE UNTIL NEXT SCHEDULED EVALUATION: ________

SIGNATURE: _________________________________ DATE: _________________
```

Figure G-81: Sample Medication Reorder Doc by Name supplement

```
PREDIABETES PATIENT CARE SUMMARY   Report Date: Oct 08, 2008
Patient Name: SIGMA,JANE HRN: 222222
Age: 10  Sex: F DOB: Oct 07, 1998

Classification:
 No Impaired Fasting Glucose
 No Impaired Glucose Tolerance
 No Metabolic Syndrome

Case Manager:
Primary Care Provider:

Last Height:
Last 3 Weight: 86 lbs   May 27, 2006 BMI:
            BMI:
            BMI:

Last 3 non-ER BP:  None recorded

Tobacco Use: UNDOCUMENTED

Prediabetes Education Provided (in past yr):
 Last Dietitian Visit:
  <No Education Topics recorded in past year>

HTN Diagnosed: No
ON ACE Inhibitor/ARB in past 6 months: No
Aspirin Use (in past yr): N
On Metformin: No
On TZD: No
On Acarbose: No
On Lipid Lowering Drugs: No

Laboratory Results (most recent):
Last Fasting Glucose:
Last 75 GM 2 hour Glucose:

Total Cholesterol:
 LDL Cholesterol:
 HDL Cholesterol:
```

```
 Triglycerides:
```

Figure G-82: Sample Pre-Diabetes Care Summary supplement

G.62 Treatment Contracts

This component displays the treatment contracts.

G.63 Treatments Provided

Treatments and procedures performed within the time and occurrence constraints appear in this component. The date of the patient encounter, the site, and the treatment or procedure performed display on a single line. The information that appears in this component is retrieved from the Treatments Provided file. The types of treatments and codes displayed in this component are determined at each site and must be typed into the Treatments Provided file. The data recording and entry conventions also must be locally developed.

```
------------TREATMENTS PROVIDED (max 5 visits or years)------------
12/10/07 DEMO HOSP FOOT CARE
     APPLY/REMOVE BRACE/SLING, CAST
```

Figure G-83: Example of the Treatments Provided component

G.64 Well Child Exam

This component displays the data for the Well Child Exam regarding patient education data, data gathered during a general health screening, age-specific physical exam, special risk screening, and behavioral health screening.

G.65 Health Summary Types

There are several predefined, standard health summary types delivered with the PCC Health Summary system distribution. The predefined types are:

- Adult Regular
- Behavioral Health
- Community Health Representative (CHR)
- Dental
- Diabetes Standard
- Immunization
- Patient Merge (Complete)
- Pediatric

- Problem List

These standard summary types contain the components that healthcare providers most commonly rely on to assess a patient's health status and care needs. They differ in terms of primary focus and the data displayed. Each of the standard summary types is described in detail below.

The description of each health summary type includes a list of the components that are included and the display restrictions, if any, noted in parentheses following the component name. The restrictions are abbreviated as follows. The letter X signifies number of occurrences and the letter Y signifies years; for example, 5X/2Y indicates the data is limited to five occurrences or two years. The provider narrative is set to display in these summaries, as applicable.

In addition to the standard health summary types, the user can create additional types at a facility that are specific to a site, clinic, or health problem. The user will be able to select the components to appear on the summary, order of appearance, and the date and visit restrictions for each one. The procedures for building customized Health Summaries are described in detail in the Section 4.0.

G.65.1 Adult Regular

The Adult Regular Health Summary is the most frequently used summary type. Go to the Adult Regular Health Summary example to view an example. The comprehensive overview of the patient's health status provided by the Adult Regular Health Summary maximizes the provider's ability to plan for and provide care to outpatient, emergency room, and home health patients.

The components displayed on the Adult Regular Health Summary are listed below in the order in which they display in the report.

- Demographic Data
- Allergies (from problem list)
- Allergies/Adverse Reactions (from allergy tracking
- Measurement Panels (5X/2Y)
- Active Problems
- History of Surgery
- Meds - most recent of each (max. 1 year)
- Scheduled Encounters (include chart REQ. and Walk Ins) (max 10 visits or 90 days)
- In Hospital Visits (max 10 visits or 2 years)
- Outpatient/Field Visits (max. 10 visits or 2 years)

- Referred Care (max. 10 visits or 2 years)
- Treatments Provided (max. 25 visits)
- Most Recent Radiology Studies (max. 10 visits or 5 years)
- Most Recent Laboratory Data (max. 1 year)
- Most Recent Examinations
- Immunizations
- Health Maintenance Reminders

G.65.2 Behavioral Health

The Behavioral Health Summary displays information

- Demographic Data
- Allergies (from problem list)
- PCC Active Problems
- In-Hospital Visits (max. 10 visits or 2 years)
- PCC Outpatient Visits (max. 10 visits or 2 years)
- PCC Current Medications (max. 1 year)
- Laboratory Data (max. 5 visits)
- Most Recent of Each Lab Test (max. 1 year)
- Behavioral Health (max. 20 visits or 2 years)
- PCC Measurements Taken (max. 3 visits or 2 years)
- Treatments Provided (max. 3 visits or 2 years)

G.65.3 Community Health Representative (CHR)

The Community Health Representative (CHR) Health Summary displays information typed in the CHR System. Patient-related data from the PCC also display. The following components display in the CHR Health Summary:

- Demographic Data
- CHR (max. 10 visits or 2years)

G.65.4 Dental

The Dental Health Summary is printed prior to a patient's dental visit. Both demographic and clinical information displays for use by administrative staff and healthcare providers. Below are the components that display:

- Demographic Data
- Allergies From Problem List
- Measurement Panels (max. 5 visits or 2 years)
- Active Problems
- Outpatient/Field Visits (max. 10 visits or 2years)
- Dental (max. 10 visits or 3 years)

G.65.5 Diabetes EHR

The Diabetes EHR Summary is

- Minor Surgery History (max. 1 year)
- History of Surgery
- Referred Care (max 1 year)

G.65.6 Diabetes Standard

The Diabetes Standard Health Summary is similar to the Adult Regular summary, but more detailed information is provided for assisting with the healthcare of the diabetic patient.

- Demographic Data
- Insurance Information
- Allergies (from problem list)
- Measurement Panels (max. 5 visits or 2years)
- Reproductive History (female only)
- Active Problems
- Inactive Problems
- History of Surgery
- Health Factors
- Hospitalization Stays (max. 5 visits or 5 years)
- In-Hospital Visits (max. 10 visits or 2 years)
- Outpatient/Field Visits (max. 10visits or 2years)

- Referred Care (max. 10 visits or 2 years)
- Most Recent Patient Education (max. 5 visits or 2 years)
- Most Recent Laboratory Data (max. 1 year)
- Most Recent Examinations
- Immunizations
- All Skin Tests
- Health Maintenance Reminders
- Flowsheets (max. 1 year)
- Diabetes Patient Care Summary

G.65.7 Immunization

The Immunization Health Summary displays three components pertaining to the patient's immunization history:

- Brief Demographics
- Immunizations
- All Skin Tests

G.65.8 Patient Merge (Complete)

The Patient Merge (Complete) Health Summary is included for use by PCC data entry staff to assist with record-keeping responsibilities. The components that display in this Health Summary are:

- Demographic Data
- Insurance Information
- Active Problems
- Inactive Problems
- Allergies (from problem list)
- Allergies/Adverse Reactions (from allergy tracking))
- Family Health History
- Personal Medical History
- Hospitalization Stays
- In-Hospital Visits
- Outpatient/Field Visits

- Public Health Nursing Visits
- CHR
- History of Surgery
- Minor Surgery History
- Reproductive History
- Scheduled Encounters (includes chart REQ and Walk Ins)
- Measurements
- Laboratory Data
- Microbiology
- All Medications (includes duplicate RXs)
- Immunizations
- All Skin Tests
- Most Recent Radiology Studies
- Diagnostic Procedure
- Most Recent Examinations
- Narrative Text
- Patient Education
- Patient Refusals for Service

G.65.9 Pediatric

The Pediatric Health Summary was specifically designed for use by pediatric healthcare professionals to assist in providing effective care for their patients. The components that display in this Health Summary are:

- Demographic Data
- Allergies (From Problem List)
- Allergies/Adverse Reactions (from Allergy Tracking)
- Outpatient/Field Visits (max.10 visits or 2 years)
- In-Hospital Visits (max.10 visits or 2 years)
- Referred Care (max. 1 year)
- Immunizations
- Health Maintenance Reminders

G.65.10 Problem List

The information presented in the Problem List Health Summary focuses on the patient's current health problems and latent problems that could potentially affect the patient's health in the future. This Health Summary displays four components:

- Brief Demographics
- Active Problems
- History of Surgery

Appendix H: PWH Components and Logic

H.1 PWH Component Descriptions and Logic

This section contains descriptions and detailed logic for each of the available components. The components are arranged alphabetically.

H.1.1 Activity Level

This component displays a message regarding the last documented health factor in the category Activity Level.

If Physical Activity health factor is blank, this component does not display.

If Physical Activity health factor is “Very Active,” the following text displays: “Your level of physical activity is outstanding! You are working hard and it shows. Keep up the good work and stay on track.”

If Physical Activity health factor is “Active,” the following text displays: “Your level of physical activity is excellent! Increasing your physical activity level to 300 minutes each week (60 minutes/day) helps you get even more health benefits.”

If Physical Activity health factor is “Some Activity,” the following text displays: “Increasing your physical activity to 150 minutes each week (30 minutes/day) helps you gain even more health benefits. Now you are on the way to losing weight and better health.”

```
If Physical Activity health factor is “Inactive,” the following text
displays: ”Increasing your physical activity to 10 minutes each day
helps you get more energy, lowers stress, and helps to improve your
strength. Being active will help you feel better.”ACTIVITY LEVEL -
Increasing your physical activity to 10 minutes each day helps you
get more energy, lowers stress, and helps to improve your strength.
Being active will help you feel better.
```

Figure H-1: Example of Activity Level component

H.1.2 Allergies

This component displays a message regarding the allergies documented in the Problem List, the Allergy Tracking system, or both. The user is prompted to choose. The Adult Regular and Medication Reconciliation handouts display both.

The following standard text displays: “It is important to know what allergies and side effects you have to medicines or foods.”

The system identifies allergies from the PCC Active Problem List using the same code set the Health Summary uses.

- **Problem List Allergies Definition**: If the ICD9 code associated with the problem is one of the following, it is assumed to be an allergy:
  - 629.3, 693.0, 995.0, 995.2, 999.4-999.89, V14.*, 692.5, 693.1, V15.*, 692.*, (not including 692.9), 693.8, 693.9, 989.5, 989.82, 995.3, 995.2*, OR
  - 799.9 or V82.9 with a narrative that contains the phrases NO KNOWN ALLERG, NKA, NKDA or NO KNOWN DRUG ALLERG.

The system gathers all allergies from the Allergy Tracking System.

If no allergy data is available, the system displays the following message: “No allergies are on file. Please tell us if there are any that we missed.”

If allergy data *is* available, the system displays the following message: “Below is a list of allergies that we know of. Please tell us if there are any that we missed.”

```
ALLERGIES - It is important to know what allergies and side effects
you have to medicines or foods.
Below is a list of allergies that we know of. Please tell us if
there are any that we missed.

 WINE
 SULFAMETHOXAZOLE
```

Figure H-2: Example of Allergies component

H.1.3 Ask Me 3 Questions

The “Ask Me 3 Questions” is a hard-coded component that displays the following:

```
Ask Me 3 – Every time you talk with a doctor, nurse, pharmacist, or
other healthcare worker, use the Ask Me 3 Questions to better
understand your health. Make sure you know the answers to these
three questions:
1. What is my main problem?
2. What do I need to do?
3. Why is it important for me to do this?
```

Figure H-3: Example of Ask Me 3 Questions component

H.1.4 Blood Pressure

This component only displays if the patient is 18 or older. The system retrieves the last BP measurement on file in V MEASUREMENT.

The following standard text displays: “BLOOD PRESSURE – Blood pressure is a good measure of health.”

If BP data *is not* available, the system displays the following message: “You should have your blood pressure checked at your next visit.”

If blood pressure data *is* available, then the system displays the following message: “Your last blood pressure was [measure] over [measure] on [MMM DD, YYYY].”

If the BP found is greater than one year old (365 days), the system displays the following message and does no further processing: “You should have your blood pressure checked every year or more often. Ask your provider to check your blood pressure at your next visit.”

The system determines if the patient is diabetic using the following logic:

- Diabetes diagnosis in the PCC Active Problem List, defined in [SURVEILLANCE DIABETES] taxonomy;
- An iCare Diabetes diagnostic tag of “A” (Active) or “P” (Proposed); or
- Having “n” number of visits in a certain time period as defined for the Diabetes Supplement in the Health Summary site parameters.
- If the Diabetes Supplement parameters are not set up, there must be at least 1 Diabetes diagnosis (POV) in the past year, defined in [SURVEILLANCE DIABETES] taxonomy.

The system determines if the patient has chronic kidney disease if at least one of the following elevated labs exists:

- If the patient has at least one of the following elevated lab results ever. Creatinine is greater than (>)1.3 for females; greater than (>)1.5 for males, defined in [DM AUDIT CREATININE TAX] or [BGP CREATININE LOINC CODES] taxonomies.
- Urine protein is greater than (>) 200, defined in [DM AUDIT URINE PROTEIN TAX] or [DM AUDIT URINE PROTEIN LOINC] taxonomies.
- A/C ratio is greater than (>) 200, defined in the [DM AUDIT A/C RATIO TAX] or [DM AUDIT A/C RATIO LOINC] taxonomies.
- Estimated GFR is less than (<) 60, defined as [BGP GPRA ESTIMATED GFR TAX] or [BGP ESTIMATED GFR LOINC] taxonomies

If the patient is *not* DM or CKD *and* the last recorded diastolic was greater than (>) 90 OR the last systolic greater than (>) 140, the system displays the following message: “Your blood pressure is too high. Eating healthy foods, cutting back on salt, and more physical activity can help lower blood pressure. If you take medicine to lower your blood pressure, be sure to take it every day.”

If the patient does *not* have either DM or CKD *and* the last recorded diastolic was equal to or less than (=<) 90 OR the last systolic was equal to or less than (=<) 140, the following text displays: “Your blood pressure is good! It is very important to have your blood pressure checked often.”

If the patient *is* DM, the system displays the following message: “Since you have diabetes, knowing your blood pressure helps you see how well your treatment is working.”

If the patient *is* DM or CKD *and* the last recorded diastolic was greater than (>) 80 *or* the last systolic was greater than (>) 130, the system displays the following message: “Your blood pressure is too high. Eating healthy foods, cutting back on salt, and more physical activity can help lower blood pressure. If you take medicine to lower your blood pressure, be sure to take it every day.”

If the patient *is* DM or CKD *and* the last recorded diastolic was less than (<) 80 *or* the last systolic was less than (<) 130, the system displays the following message: “Your blood pressure is good! It is very important to have your blood pressure checked often.”

```
BLOOD PRESSURE - Blood Pressure is a good measure of health.

Your blood pressure was 109/64 on Feb 08, 2007.
Since you have diabetes, knowing your blood pressure helps you see
how well your treatment is working.
Your blood pressure is good! It is very important to have your blood
pressure checked often.
```

Figure H-4: Example of the Blood Pressure component

H.1.5 Cancer Screening

This component displays information about breast cancer (mammogram), cervical cancer (pap smear), and colorectal cancer. The system uses the HMR logic for the following items and displays text depending on the screening that the patient receives.

H.1.5.1 Mammogram

The Mammogram item only displays if the patient is a female between ages 50 and 69. The system retrieves the last mammogram on file using the following logic:

- V Radiology with CPT in [BGP CPT MAMMOGRAM] taxonomy
- Diagnosis–V POV V76.11, V76.12
- Procedures: 87.36, 87.37
- V CPT: [BGP CPT MAMMOGRAM] taxonomy
- Women's Health Procedures: MAMMOGRAM SCREENING, MAMMOGRAM DX UNILAT, MAMMOGRAM DX BILAT

The system determines how old the mammogram is in days. If no mammogram is found, the system displays the following message: "No mammogram on file. It is recommended that you receive a mammogram every year. Ask your healthcare provider to order a mammogram for you."

If a mammogram was found and it was in the past year, the system displays the following message: "Your last mammogram was on [DATE]. Your next mammogram will be due on [DATE - 1 year from now]."

If a mammogram was found and it was not in the past year, the system displays the following message: "Your last mammogram was on [DATE]. It is recommended that you receive a mammogram every year. Ask your health care provider to order a mammogram for you."

H.1.5.2 Pap Smear

The Pap Smear item only displays if the patient is a female older than 18 years. This item does not display for women with a history of hysterectomy. Hysterectomy defined as:

- V Procedure: 68.3, 68.4, 68.5, 68.6, 68.7, 68.9
- V CPT: taxonomy [BGP HYSTERECTOMY CPTS]
- V POV: 618.5
- Women's health procedure: HYSTERECTOMY

The system retrieves the last documented Pap Smear using the following logic:

- Lab Test: V Lab "PAP SMEAR" or defined in [BGP PAP SMEAR TAX] or [BGP PAP LOINC CODES] taxonomy
- Diagnosis (ICD): V POV defined in [BGP PAP SMEAR DXS] taxonomy
- Procedures (ICD): V Procedures 91.46
- Procedures (CPTs): V CPT defined in [BGP CPT PAP] taxonomy
- Women's Health Procedures: PAP SMEAR

The system determines how old the pap smear is in days. If no pap smear is found, the system displays the following message: "No PAP Smear no file. It is recommended that you receive a PAP Smear every 3 years. Ask your healthcare provider to order a PAP Smear for you."

If a pap smear is found and it was in the past three years (3*365 days), the system displays the following message: "Your last Pap Smear was on [DATE]. Your next Pap Smear will be due on [DATE–3 years from now]."

If a pap smear is found and it was not in the past year, the system displays the following message: "Your last PAP smear was on [DATE]. It is recommended that you receive a PAP smear every 3 years. Ask your health care provider to order a PAP smear for you."

H.1.5.3 Colon Screening

This element only displays only for patients 51 or older without a documented history of colorectal cancer. The definition for Colorectal Cancer is if the patient has any of the following:

- Diagnosis (ICD): Active Problem List or V POV, defined in [BGP COLORECTAL CANCER DXS] taxonomy
- Procedures (CPTs): V CPT ever, defined in either [BGP COLORECTAL CANCER CPTS] or [BGP TOTAL CHOLECTOMY CPTS] taxonomies.
- Procedures (ICD): V Procedure, defined in [BGP TOTAL CHOLECTOMY PROCS].

The system identifies the most recent colonoscopy in the past ten years.

The system retrieves the last colonoscopy in the past ten years. Colonoscopy is defined as:

- V Procedure 45.43, 45.22, 45.23, 45.25
- Procedures (CPTs): V CPT, defined in[BGP COLO CPTS] taxonomy

The system retrieves the last barium enema in the past 10 years. Barium enema is defined as:

- Procedures (CPTs): V Radiology or V CPT, defined in [BGP BE CPTS] taxonomy.
- Procedures (ICD): V Procedure 87.64

The system retrieves the last sigmoidoscopy in the past five years. Sigmoidoscopy is defined as:

- Procedures (ICD): V Procedure: 45.24, 45.42
- Procedures (CPTs): V CPT, defined in [BGP SIG CPTS] taxonomy

The system retrieves the last FOBT in the past year. FOBT is defined as:

- Lab Test: V Lab, defined in [BGP GPRA FOB TESTS] or [BGP FOBT LOINC CODES] taxonomies
- Procedures (CPTs): V CPT, defined in [BGP FOBT CPTS] taxonomy.

If none of the above four items are found in the appropriate timeframe, the following message displays: “It is recommended that all people who are 50 years and older be screened for colon cancer. Ask your health care provider to order a colon cancer screening for you.”

If at least one of the above four items was found in the appropriate timeframe, the system determines which of the four (if there are more than one) has the greatest next due date. For example, if FOBT is due 1/1/09 and the colonoscopy is due 1/1/2011, the system uses 1/1/2011) and displays the following message: “You are up to date for colon cancer screening. Your next colon cancer screening will be due on [one year from last FOBT or five years from last sigmoidoscopy, or 10 years from last documented colonoscopy or barium enema].”

```
CANCER SCREENING

Mammogram - No mammogram no file. It is recommended that you receive
a mammogram every year. Ask your health care provider to order a
mammogram for you.

Pap Smear - Your last Pap Smear was on 5 June 2008. Your next Pap
Smear will be due on 5 June 2011.

Colorectal Cancer - It is recommended that all people who are 50
years and older be screened for colon cancer. Ask your healthcare
provider to order a colon cancer screening for you.
```

Figure H-5: Example of Cancer Screening component

H.1.6 Cholesterol

This component will not display for anyone under 18 years of age. The system displays the following message: “Cholesterol - Controlling your cholesterol can keep your heart and blood vessels healthy.”

The system retrieves the latest of each of the following tests:

- Total cholesterol: Searches V LAB for the last Total Cholesterol test with a value/result. Uses the [DM AUDIT CHOLESTEROL TAX] laboratory taxonomy and the [BGP TOTAL CHOLESTEROL LOINC] taxonomy.
- LDL: Searches V LAB for the last LDL test with a value/result. Uses the [DM AUDIT LDL CHOLESTEROL TAX] laboratory taxonomy and the [BGP LDL LOINC] taxonomy.
- HDL: Searches V LAB for the last HDL test with a value/result. Uses the [DM AUDIT HDL TAX] laboratory taxonomy and the [BGP HDL LOINC] taxonomy.
- Triglyceride: Searches V LAB for the last Triglyceride test with a value/result. Uses the [DM AUDIT TRIGLYCERIDE TAX] laboratory taxonomy and the [BGP TRIGLYCERIDE LOINC] codes taxonomy.

If no tests are found, the system displays the following message: “No recent cholesterol is on file. You should have your cholesterol rechecked at your next visit.”

If some or all of the tests are found, the system displays the test, result, and date for each test as follows:

- Your total cholesterol was XX on mmm dd, yyyy.
- Your last LDL (bad cholesterol) was XX on mmm dd, yyyy.
- Your last HDL (good cholesterol) was XX on mmm dd, yyyy.
- Your last triglyceride was XX on mmm dd, yyyy.

If the test value was not found, the system displays "No test result found on file."

If there is an LDL value on file (in the list above), the system will determine whether or not the patient is diabetic using the logic of having diabetes:

- Diabetes diagnosis on the PCC Active Problem List, defined in [SURVEILLANCE DIABETES] taxonomy;
- An iCare diagnostic tag of "A" (Active) or "P" (Proposed); or
- Having n number of visits in a certain time period as defined for the Diabetes Supplement in the Health Summary site parameters.
- If the Diabetes Supplement parameters are not setup, then there must be at least 1 Diabetes diagnosis (POV) in the past year, defined in [SURVEILLANCE DIABETES] taxonomy.
- Any diagnosis (V POV) in the past 365 days for acute myocardial infarction or ischemic vascular disease, defined in the [BGP AMI DXS (HEDIS)] or [BGP IVD DXS] taxonomies.
- Any procedure for coronary artery bypass graft (CABG) in the past 365 days, defined in the [BGP CABG PROCS] taxonomy.
- Any procedure for percutaneous transluminal coronary angioplasty (PTCA) in the past 365 days, defined in the [BGP PTCA PROCS] taxonomy.
- Any CPT for CABG in the past 365 days that is contained in the [BGP CABG CPTS] taxonomy.
- Any CPT for percutaneous transluminal coronary angioplasty (PTCA) in the past 365 days, defined in the [BGP PTCA CPTS] taxonomy.

If the patient is diabetic or has CVD and the LDL ≤ 100mg/dl, the system displays the following message: "LDL (bad cholesterol) should be under 101 mg/dL. Your LDL cholesterol is good! You should have your cholesterol checked every year."

If patient is diabetic or has CVD and the LDL > 100mg/dl, the system displays the following message: "It is best when your LDL (bad cholesterol) is less than 101 mg/dL. Ask your provider about ways to lower your cholesterol."

If the patient has diabetes or CVD *and* the earliest date of the four tests documented is *not* in the past year (365 days); *or* if the patient does *not* have diabetes or CVD *and* the earliest date of the 4 tests documented is *not* in the past 5 years (1,825 days) the following text displays: “No recent cholesterol is on file. You should have your cholesterol rechecked at your next visit.”

If patient had a triglyceride value *and* the triglyceride result is greater than (>) 500mg/dl (regardless of disease), the following text displays: “High triglyceride levels can hurt your pancreas and cause health problems such as pain and poor digestion. Ask your provider about how you can get your triglycerides less than 500 mg/dL.”

```
CHOLESTEROL
Controlling your cholesterol can keep your heart and blood vessels
healthy.

Your total cholesterol result was 183 mg/dL on Nov 15, 2005.
Your last LDL (bad cholesterol) result was 112 on Nov 15, 2005.
Your last HDL (good cholesterol) result was 3.6 on Nov 15, 2005.
Your last triglyceride result was 102 on Nov 15, 2005.

It is best when your LDL (bad cholesterol) is less than 100 mg/dl.
Ask your provider about ways to lower your cholesterol.

No recent cholesterol is on file. You should have your cholesterol
rechecked at your next visit.

High triglyceride levels can hurt your pancreas and cause health
problems such as pain and poor digestion. Ask your provider about
how you can get your triglycerides less than 500 mg/dL.
```

Figure H-6: Example of Cholesterol component

H.1.7 Demographic Component

This component is standard on each handout type. It is always printed and is not an optional component.

This display has the following format:

```
PATIENT,JOAN M HRN: 100019    DEMO HOSPITAL
900 RIVER PLACE       CHICAGO, ILLINOIS 77788
MY TOWN, ARIZONA 12121      JONES, DOCTOR
555-555-0010          555-555-1234

Thank you for choosing DEMO HOSPITAL.
This handout is a new way for you and your doctor to look at your
health.
```

Figure H-7: Sample demographic information display

- **Patient Last Name, First Name, HRN, Address and Phone Number**: Taken from the Patient file, which is updated by patient registration.
- **Facility Name**: Uses the value in the Facility Print Name field in the PCC Master Control file for the site in which the user is logged in. If that value is blank, the system displays the name of the facility in the LOCATION file for the location where the user is logged in.
- **Provider Name**: The designated primary care provider displays. If none exists, no provider name displays. Provider names are taken from the RPMS Designated Specialty Provider Management System (BDP) package. If the facility is not using DSPM, the value is taken from the Designated Provider field of the Patient file.
- **Provider Phone Number**: Facility phone number, which is obtained from the Phone Number field of the LOCATION file for the site in which the user is logged in.

H.1.8 Diabetic Care

This component covers all elements of a Comprehensive Diabetes assessment, including A1c value, kidney assessment, nephropathy assessment, retinal screen, and foot exam.

If the patient does not have diabetes, this component does not display.

- **Diabetes Definition**: The patient has one of the following:
  - Diabetes diagnosis in the PCC Active Problem List, defined in [SURVEILLANCE DIABETES] taxonomy;
  - An iCare diagnostic tag of “A” (Active) or “P” (Proposed); or
  - *n* number of visits in a certain time period as defined for the Diabetes Supplement in the Health Summary site parameters.
  - At least 1 Diabetes diagnosis (POV) in the past year, defined in [SURVEILLANCE DIABETES] taxonomy, if the Diabetes Supplement parameters are not set up

If the patient has diabetes, the following title text displays:

```
DIABETES CARE.
A1c
```

Figure H-8: Example title text for the Diabetic Care component

The following standard text displays:

```
HEMOGLOBIN A1c
Hemoglobin A1c is a test that measures your blood sugar control over
a 3-month period. You should have this test done every 3-6 months.
```

```
The system identifies the most recent Hemoglobin A1c test that has a
result/value.
```

Figure H-9; Example of Hemoglobin A1c standard text

- **Hemoglobin A1c Definition**:
  - Lab Test: V LAB, defined in the [DM AUDIT HGB A1C TAX] or the [BGP HGBA1C LOINC CODES] taxonomies.

If no test is found or if last A1c is more than 1 year (365 days) ago, the following text displays: “You are due to have your A1c tested. Ask your healthcare provider to order an A1c test for you.”

If a test was found that was done in the last year, the following text displays: “Your last A1c test on file was [value] done on [DATE].”

If A1c was done in the last year *and* the result is less than 7%, the following text displays: “An A1c value that is less than 7% shows great blood sugar control. You are doing great!”

If A1c was done in the last year *and* result is 7-9%, the following text displays: “An A1c value that is less than 9% shows that you have good control of your blood sugar. Ask your healthcare provider how you can keep lowering your A1c!”

If A1c was done in the last year *and* result is greater than 9%, the following text displays: “Your A1c is too high. Ask your health care provider about ways to lower your A1c.”

H.1.8.1 Diabetes Kidney Assessment

The following standard text displays:

```
Diabetes Kidney Assessment
Diabetes can cause kidney damage. There are tests that can see how
well your kidneys are working. Getting these tests at least once a
year can help your health care provider protect your kidneys and
lower your risk of getting kidney damage and dialysis.
```

Figure H-10: Example Diabetes Kidney Assessment text

The system identifies the most recent kidney test done in the past year (365 days).

- **Kidney Test Definition**: The patient has one of the following:
  - Lab Test: V LAB, defined in any of the following: [DM AUDIT A/C RATIO TAX], [DM AUDIT A/C RATIO LOINC], [DM AUDIT P/C RATIO TAX], [DM AUDIT P/C RATIO LOINC], [BGP QUANT URINE PROTEIN], or [BGP QUANT URINE PROT LOINC] taxonomies.

If the patient did *not* have a kidney laboratory test in the past year, the following text displays: “You should have your kidneys tested to see how well they are working every year. Ask your health care provider to order a kidney function test for you.”

If patient had a kidney laboratory test in the past year the following text displays: “Your kidneys were tested on [DATE]. You will need to have your kidneys tested again on [Test Date + 365 days].”

H.1.8.2 Diabetes Eye Exam

The following standard text displays: “Diabetes can affect your eyes and vision. Early detection of eye problems can help you to get the treatment you need to lower your chances of having problems such as blurred vision or blindness.”

The system retrieves the last eye exam done in the past year (365 days).

- **Diabetes Eye Exam Definition**: The patient has any of the following in the past year:
  - **Exam**: V Exam 03 DIABETIC EYE EXAM
  - **Diagnosis (ICD)**: V POV V72.0
  - **Procedures (ICD)**: V Procedure 95.02
  - **Procedures (CPTs)**: V CPT, defined in [BGP DM RETINAL EXAM CPTS] or [BGP DM EYE EXAM CPTS] taxonomies
  - **Provider Class Codes**: Any visit to an Optometrist or Ophthalmologist (provider class codes: 24, 79, 08) that does not have a DNKA narrative
  - **Clinic Codes**: Any visit to an Optometry or Ophthalmology Clinic (clinic codes: 17, 18, 64, or A2).

If the patient did *not* have an eye exam, the following text displays: “You should have at least one diabetes eye exam every year. Ask your health care provider to order a diabetes eye exam for you.”

If the patient had an eye exam in the past year, the following text displays: “Your last diabetes eye exam was done on [DATE]. You will need to have another eye exam by [Exam Date + 1 year (365 days)].”

H.1.8.3 Diabetes Foot Exam

The following standard text displays: “Diabetes can make your feet hurt or feel numb. Having a diabetes foot exam every year can help to lower the chance of losing feeling in your feet, getting an infection, or having an amputation.”

The system retrieves the most recent diabetic foot exam in the past year (365 days).

- **Diabetic Foot Exam Definition**: The patient has one of the following in the past year:
  - Exams: V EXAM 28 Diabetic Foot Exam
  - Provider Class Codes: Any visit to a podiatrist (provider code 28 or 33 or 25 or 84)
  - Clinic Codes: Any visit to podiatry clinic (clinic code 65)

If the patient did *not* have a diabetes foot exam the following text displays: “You should have at least one diabetes foot exam every year. Ask your health care provider to order a diabetes foot exam for you.”

If the patient had a diabetes foot exam in the past year, the following text displays: “Your last diabetes foot exam was done on [DATE]. You will need to have another foot exam by [Exam Date + 1 year (365 days)].”

Example of Diabetes Care

```
DIABETES CARE

HEMOGLOBIN A1c
Hemoglobin A1c is a test that measures your blood sugar control over
 a 3-month period. You should have this test done every 3-6 months.
Your last A1c test on file was done on Oct 07, 2008.

DIABETES KIDNEY ASSESSMENT
Diabetes can cause kidney damage. There are tests that can see how well
your kidneys are working. Getting these tests at least once a year can help
your healthcare provider protect your kidneys and lower your risk of
getting kidney damage and dialysis.

You should have your kidneys tested to see how well they are working every
year. Ask your health care provider to order a kidney function test for
you.

DIABETES EYE EXAM
Diabetes can affect your eyes and vision. Early detection of eye problems
can help you to get the treatment you need to lower your chances of having
problems such as blurred vision or blindness.

You should have at least one diabetes eye exam every year. Ask your
healthcare provider to order a diabetes eye exam for you.

DIABETES FOOT EXAM
Diabetes can make your feet hurt or feel numb. Having a diabetes foot exam
every year can help to lower the chance of losing feeling in your feet,
getting an infection, or having an amputation.
```

```
You should have at least one diabetes foot exam every year. Ask your
healthcare provider to order a diabetes foot exam for you.
```

Figure H-11: Example of Diabetes Care component

H.1.9 Healthcare Goals

This component displays any goals a patient has set through patient education in the past year. The system retrieves any education topic entered into V Patient Education that has either the Goal code or the Goal Comment populated.

The system displays the following: “My Healthcare Goals.” It then lists any goals that were documented.

```
My Healthcare Goals

 Goal: MONITOR FEET
 Goal: BUY FOODS WITH MORE THAN 3 GRAMS OF FIBER PER SERVING.
```

Figure H-12: Example of Healthcare Goals component

H.1.10 Height/Weight/BMI

This component will only display for patients 19 years and older.

This component will not display if any visit in the past 90 days contains a Purpose of Visit of Prenatal/Pregnancy.

Logic for determining pregnancy: Any visit (ambulatory, observation, day surgery, or hospitalization) in the past three months (90 days) with a primary or secondary purpose of visit contained in the [BGP GPRA PREGNANCY DIAGNOSES] taxonomy.

First, the following standard text displays: “Weight and Body Mass Index are good measures of your health. Determining a healthy weight and Body Mass Index also depends on how tall you are.”

The system retrieves the most recent Height (measurement type HT) and the most recent Weight (measurement type WT) from the V MEASUREMENT FILE.

The system retrieves the patient’s age in years as of the date the handout is run.

The system determines whether the HT or WT data is out of date (not current) based on the following logic:

- For ages19 through 50, height and weight must be within the last five years, not required to be on same day.

- For ages over 50, height and weight must be within the last two years, not required to be on same day.

The handout displays messages according to the following logic:

If the Height is current and weight is either not current or has never been entered, the following displays: “You are [feet] feet and [inches] inches tall.” *or* “No recent weight is on file. You should have your weight rechecked at your next visit.”

If the Weight is current and the height is either not current or has never been entered, the following displays: “Your last weight was [xxx] pounds on [MMM, DD, YYYY].” *or* “No recent height is on file. You should have your height rechecked at your next visit.”

If neither the Height nor Weight is current, the system displays: “No recent weight is on file. You should have your weight rechecked at your next visit.” *or* “No recent height is on file. You should have your height rechecked at your next visit.”

If both the Height and Weight values are current the system displays the following: “You are [feet] feet and [inches] inches tall. Your last weight was [number] pounds on [MMM DD, YYYY]. You should have your weight rechecked at your next visit.”

If, and only if, both the Height and Weight are current, the system calculates the patient’s BMI using the last weight and height recorded. Given H is Height in inches and W is weight in lbs., the calculation is:

S W=W*.45359,H=(H*0.0254),H=(H*H),%=(W/H),%=$J(%,4,1)

This is weight in kilograms divided by height in meters squared.

Once calculated the system displays: “Your Body Mass Index on [MMM DD, YYYY] was [BMI].”

If the patient’s BMI is between 18–25, the following message displays: “You are at a healthy weight. Keep up the good work!”

If the patient’s BMI is greater than or equal to (≥) 26, the following message displays: “You are above a healthy weight. Ask your healthcare provider about a weight that is good for you.”

If the patient’s BMI is less than or equal to 17, the following message displays: “Your current BMI is below normal. Ask your healthcare provider about a weight that is good for you.”

Below is an example of the Height/Weight/BMI component.

```
HEIGHT/WEIGHT/BMI - Weight and Body Mass Index are good measures of
your health. Determining a health weight and Body Mass Index also
depends on how tall you are.

You are 5 feet and 4 inches tall.
Your last weight was 254 on Mar 12, 2008.
You should have your weight rechecked at your next visit.

Your Body Mass Index on Mar 12, 2008 was 43.5.
You are above a healthy weight. Ask your healthcare provider about a
weight that is good for you.
```

Figure H-13: Example of Height/Weight/BMI component

H.1.11 HIV Screening

This component does not display, if the patient's age is less than 13 years or greater than 64 years. If HIV screening has taken place, this component does not display.

If the patient has HIV/AIDS, this component does not display.

- **HIV/AIDS Definition**: The patient has any of the following:
  - iCare HIV diagnostic tag of "P" (Proposed) or "A" (Active)
  - Any HIV/AIDS diagnosis on the PCC Active Problem list, defined in the [BGP HIV/AIDS DXS] taxonomy
  - Any HIV/AIDS diagnosis in V POV in the past year, defined in the [BGP HIV/AIDS DXS] taxonomy

The system looks to see if the patient has had an HIV test in the past five years.

- **HIV Test Definition**: The patient has any of the following:
  - Procedure (CPT): V CPT, defined in the [BGP CPT HIV TESTS] taxonomy.
  - Lab Test: V Lab, defined in [BGP HIV TEST TAX] or [BGP HIV TEST LOINC CODES] taxonomies

If there is no HIV screening, the following displays: "Screen for Human Immunodeficiency Virus (HIV). HIV is a virus that causes a serious infection. HIV infection can cause sickness and death. A person can have HIV for many years and not know it. Everyone should be tested for HIV when they are between 13 and 64 years old. According to our records, you have not had an HIV test. Ask your provider about how you can get an HIV test."

```
Screen for Human Immunodeficiency Virus (HIV).
HIV is a virus that causes a serious infection. HIV infection can
cause sickness and death. A person can have HIV for many years and
not know it. Everyone should be tested for HIV when they are between
13 and 64 years old. According to our records, you have not had an
HIV test. Ask your provider about how you can get an HIV test.
```

Figure H-14: Example of HIV Screening component

H.1.12 Immunizations Due

For the selected patient, the system calls the immunization data from the Immunization Forecaster. This is the same logic used by the Health Summary. Only the Immunization Forecaster is used to project immunizations that are due. The Wellness handout logic does *not* use the Flu and Pneumovax HMRs, as the Forecaster has been updated to include those two reminders.

If the Immunization Forecaster is not running at the facility, the following message displays: “IMMUNIZATIONS (shots). Ask your doctor if you are due for any immunizations.”

If immunizations *are not due*, the system displays the following message: “Immunizations (shots). Getting shots protects you from some diseases and illnesses. Your immunizations are up to date.”

If immunizations *are due*, the system displays the following message: “Immunizations (shots). Getting shots protects you from some diseases and illnesses. It is time for you to get these shots:

[Name of Immunization]

[Name of Immunization]”

Please note: If the immunization forecaster is not operational at this facility, this component will not display.

If immunization data *is not* available, the system displays the following message: “No immunizations are on file.”

```
1 Immunization Due
 Tdap
```

Figure H-15: Example of Immunizations Due component

H.1.13 Immunizations Received

For the selected patient, the system calls the same immunization logic as the Health Summary, which pulls data from Immunization Forecaster.

> **Note**: If the Immunization Forecaster is not operational at this facility, the V Immunization file is reviewed and all immunizations display.

The system displays the following message: "Immunization Record – It is important to keep track of your immunizations. You received the following immunization(s):

[Name of Immunization] on [date administered]

[Name of Immunization] on [date administered]"

If immunization data *is not* available, the system displays the following message: "No immunizations are on file."

```
IMMUNIZATON (shot) RECORD - It is important to keep track of your
immunizations. You received the following immunization(s):

 DTP on 16-May-1989
 DTP on 19-May-1992

 OPV on 16-May-1989
 OPV on 19-May-1992

 MMR on 24-Jan-1989
 MMR on 19-May-1992
 RUBELLA on 02-Mar-2008

 INFLUENZA on 16-May-1989
 FLU-SPLIT on 26-Aug-2008
```

Figure H-16: Example of Immunizations Received component

H.1.14 Medications

This component displays information about the patient's medications. There are two medication components that can be added to the wellness handout: Medications (Active Only) and Medications (Active and recently expired).

The system retrieves all medications from the V MEDICATION file for the past 395 days (one year + 30 days).

The system retrieves medications from Prescription file that have a status of Active (0), Refill (2), Hold (3), Suspended (5), and Expired (11). If the status is expired the prescription must be marked as a chronic medication and the expiration date must be in the past 120 days, if not, the expired prescription is skipped. The system then reorders the list by drug name and inverse date, keeping only the latest of each different drug dispensed. For example, if aspirin 80 mg was found in the Prescription file on March 1, May 1, and June 1, only the June 1 Prescription is used in further processing/display.

The system now retrieves all “outside” medications. This is done by gathering up all medications in the V Medication file that have a value in the EHR outside med field or are attached to an Event visit.

The list of medications is put into two groups for display. Expired medications are put in the expired group and all other medications are put in the Active group.

If the user chooses the component Medications (Active Only), only the active group will display. If he/she chooses the Medications (Active and recently expired), both groups will display.

Medication Identifier	RPMS Definition/Location	Group
Active	File = 52, Field = status (active)	1
Hold	File = 52, Field = status (hold)	1
Suspended	File = 52, Field = status (suspended)	1
Expired	File = 52, Field = status (expired)	2
Outside Medication	File = V Med, either (a) EHR Outside Med (1108) or (b) an entry created from the IHS outside medication option	1

If there are any medications, the system displays: “This is a list of medications and other items you are taking, including non-prescription medications, herbal, dietary, and traditional supplements. Please let us know if this list is not complete.”

If no medications are on file, the system displays: “No medications are on file. Please tell us if there are any that we missed.”

```
MEDICATIONS - This is a list of medications and other items you are taking,
including non-prescription medications, herbal, dietary, and traditional
supplements. Please let us know if this list is not complete.
DRUG NAME, DOSAGE, DOSAGE FORM  Rx#:   Refills left:
Directions (same as appears on the label)
Last Filled date:
DRUG NAME, DOSAGE, DOSAGE FORM
Directions (same as appears on the label)
DRUG NAME, DOSAGE, DOSAGE FORM  Rx#:   Refills left:

Directions (same as appears on the label)
HOLD Reason: REFILL TO SOON - CAN REFILL ON August 4, 2008
DRUG NAME, DOSAGE, DOSAGE FORM  Rx#:   Refills left:
Directions (same as appears on the label)
DRUG NAME, DOSAGE, DOSAGE FORM  Refills left:
Directions (same as appears on the label)
============================================================
Your prescription for these medications is expired. You need to talk with your
prescriber to get a new prescription for these medications.
DRUG NAME, DOSAGE, DOSAGE FORM  Rx#:   Refills left:
Directions (same as appears on the label)
Last Filled date:     Expired on:
============================================================
```

```
These medications have been stopped. You should not take these medications. Talk to
your pharmacist about ways to safely get rid of these medications if you have them
at home.
DRUG NAME, DOSAGE, DOSAGE FORM   Rx#:   Refills left:
Directions (same as appears on the label)
```

Figure H-17: Example of Medications component

H.1.14.1 Your Health Problems (Problem List)

This component lists the patient's active problems from the problem list. The problem ICD 9 code and date of onset is also displayed.

```
Your Health Problems (Problem List)
A problem list is a listing of all of the medical conditions that
you have that don't go away quickly.

784.0   HEADACHE                                Onset: MAR 07, 2011
```

Figure H-18: Example of Problem List component

H.1.15 Recent Lab Results

This component displays laboratory tests ordered and resulted for the patient during the last 90 days. The name of the test, result, reference range and the test order date are displayed. Users may configure the component to display order comments if they wish by answering "Yes" to the " DISPLAY COMMENTS WITH LABS?: YES//" prompt when adding the component.

```
RECENT LAB RESULTS
LABORATORY TEST         RESULT          REFERENCE RANGE DATE
 HCT                    11.1 %          42-52           Feb 11, 2011
```

Figure H-19: Example of Recent Lab Results component

H.1.16 Transparency Measures Component

There are five measures in this component: Diabetes and Glycemic (A1c) Control; Diabetes and LDL Control; Diabetes and BP Control; Flu Shot (Influenza) Vaccine; and Asthma Medication Status. These five transparency measures use the CRS 2008 EO logic.

When the user creates a handout type, he/she is prompted to select which of the five he/she wants displayed on the handout. If no measures are selected, this component will not display.

The Adult Regular handout contains all five measures.

The system displays the following text: "This report looks at 5 quality measures. This report card enables you to compare your personal results to those on the IHS Quality of Care Web site at: http://www.ihs.gov/transparency. Your personal information is listed below."

H.1.16.1 Diabetes and Glycemic (A1c) Control

The system determines whether the patient is diabetic using the logic of having diabetes as described below:

- Active Problem of Diabetes in the Problem List using [SURVEILLANCE DIABETES taxonomy].
- iCare Diabetes tag (proposed or accepted).
- Using the site parameter the site has set up for the Diabetic Care Summary supplement, the system checks to see if the patient had X number of visits (default is 1) in X number of years (default is 1) with a diabetes diagnosis, where the primary provider at the visit was a primary care provider using the IHS 1A logic for determining if a provider is a PCP.

If the patient is not diabetic, the following text displays and no further processing is done: “This section only reports on people who have diabetes. You do not have diabetes, so you are not included in this report.”

The system retrieves the most recent Hemoglobin A1c test in the past year. The test is defined as:

- Lab Test: V LAB, defined in the [DM AUDIT HGB A1C TAX] or the [BGP HGBA1C LOINC CODES] taxonomies.
- CPTs: V CPT, defined in the [BGP HGBA1C CPTS] taxonomy

If no HgbA1c test was found the system displays the following text: “Your A1c was not checked in the past year. You should have your A1c checked at least twice a year.”

If a HgbA1c test was found, but it has no result, the following text displays: “Your A1c was checked on [DATE] but there is no result on file. You should ask your provider about your A1c value.”

If a HgbA1c test is found, the system displays the following text: “Your A1c value on [date] was [X]. The A1c target is less than 9%. The IHS target is less than 7%.”

H.1.16.2 Diabetes and LDL Control

The system determines whether the patient is diabetic using the logic of having diabetes as described below:

- Active Problem of Diabetes in the Problem List using [SURVEILLANCE DIABETES taxonomy].
- iCare Diabetes tag (proposed or accepted).
- Using the site parameter the site has set up for the Diabetic Care Summary supplement, the system checks to see if the patient had X number of visits (default is 1) in X number of years (default is 1) with a diabetes diagnosis where the primary provider at the visit was a primary care provider using the IHS 1A logic for determining if a provider is a PCP.

If the patient is not diabetic, the following text displays and no further processing is done: “This section only reports on people who have diabetes. You do not have diabetes, so you are not included in this report.”

The system retrieves the most recent LDL test in the past year with a value/result. LDL is found in V LAB with [DM AUDIT LDL TAX] and [BGP LDL LOINC CODES] taxonomy.

If no LDL test is found, the system displays the following text: “Your LDL was not checked in the past year. You should have your LDL checked at least once a year.”

If an LDL test is found, the system displays the following text: “Your LDL value on [date] was [X]. The LDL goal for this report is less than 100 mg/dl.”

H.1.16.3 Diabetes and BP Control

The system determines whether the patient is diabetic using the logic of having diabetes as described below:

- Active Problem of Diabetes on the Problem List using [SURVEILLANCE DIABETES taxonomy].
- iCare Diabetes tag (proposed or accepted).
- Using the site parameter the site has set up for the Diabetic Care Summary supplement, the system checks to see if the patient had X number of visits (default is 1) in X number of years (default is 1) with a diabetes diagnosis, where the primary provider at the visit was a primary care provider using the IHS 1A logic for determining if a provider is a PCP.

If the patient is not diabetic, the following text displays and no further processing is done: “This section only reports on people who have diabetes. You do not have diabetes, so you are not included in this report.”

The system retrieves the most recent BP value (V Measurement BP) in the past year.

If no BP is found the system displays the following text: “Your Blood Pressure was not checked in the past year. You should have your Blood Pressure checked at least once a year.”

If a BP is found the system displays the following text: “Your Blood Pressure on [date] was [X]. The blood pressure target for this report is less than or equal to 140/90 mmHg. The IHS target is less than 130/80 mmHg.”

H.1.16.4 Flu Shot (Influenza) Vaccine

If the patient's age is less than 50 years, the following text displays and no further processing is done: "This section only reports on people who are 50 years of age or older. You are younger than 50, so you are not included in this report."

If the patient's age is greater than 50 years, the system retrieves the last flu shot in the past year. Flu shot logic:

- IZ (CVX) Codes: V Immunization 15, 16, 88, 111
- Diagnosis (ICD): V POV V06.6, V04.81
- Procedures (ICD): V PROCEDURE 99.52
- Procedures (CPTs): V CPT, defined in [BGP CPT FLU] taxonomy

If the date of the last influenza vaccine is less than one year old, the following text displays: "You had your flu shot on [date]. You should have a flu shot every year."

If the date of the last influenza vaccine is greater than one year old, the following text displays: "You did not have a flu shot this year. You should have a flu shot every year."

H.1.16.5 Asthma Medication Status

This measure only displays for a patient aged 5–56.

Patients diagnosed with emphysema or COPD at any time are excluded and the measure does not display. Emphysema is defined as:

- Diagnosis (ICD) codes: V POV 492.*, 506.4, 518.1, 518.2, defined in [BGP EMPHYSEMA DXS] taxonomy.

COPD is defined as:

- Diagnosis (ICD) codes: V POV 491.20, 491.21, 491.22, 493.2*, 496, 506.4, defined in [BGP COPD DXS] taxonomy.

- The system determines whether the patient has persistent asthma following the CRS EO logic.
- **Asthma Definition**: If the patient has the following:
  - Diagnosis (ICD): V POV, defined in [BGP ASTHMA DXS] taxonomy
- **Persistent Asthma Definition**: The patient has at least one of the following:
  - Most recent asthma classification is 2 (Mild Persistent), 3 (Moderate Persistent) or 4 (Severe Persistent) (i.e., greater than (>) 1 (Intermittent))
  - iCare Asthma diagnostic tag of “A” (Active) or “P” (Proposed)
  - Three visits for asthma in the past 6 months

If the patient does *not* have persistent asthma, the component does not display. A dispensing event is one prescription of an amount lasting 30 days or less. For RXs longer than 30 days, divide the days’ supply by 30 and round down to convert. For example, a 100-day RX is equal to three dispensing events (100/30 = 3.33, rounded down to 3). Also, two different RXs dispensed on the same day are counted as two different dispensing events. Inhalers should also be counted as one dispensing event.

Note:	If the medication was started and then discontinued, CRS will recalculate the # Days Prescribed by subtracting the prescription date (i.e., visit date) from the V Medication Discontinued Date. Example: Rx Date=11/15/2003, Discontinued Date=11/19/2003, Recalculated # Days Prescribed=4.

Asthma medication codes for denominator defined with medication taxonomies: BGP HEDIS ASTHMA MEDS, BGP HEDIS ASTHMA LEUK MEDS, BGP HEDIS ASTHMA INHALED MEDS. The medications are:

- Antiasthmatic Combinations (Dyphylline-Guaifenesin, Guaifenesin-Theophylline, Potassium Iodide-Theophylline)

- Inhaled Steroid Combinations (Budesonide-Formoterol, Fluticasone-Salmeterol)
- Inhaled Corticosteroids (Belclomethasone, Budesonide, Flunisolide, Fluticasone CFC Free, Mometasone, Triamcinolone)
- Lekotriene Modifiers (Montelukast, Zafirlukast, Zileuton)
- Long-Acting
- Inhaled Beta-2 Agonist (Aformoterol, Formoterol, Salmeterol)
- Mast Cell Stabilizers (Cromolyn, Nedocromil)
- Methylxanthines (Aminophylline, Dyphylline, Oxtriphylline, Theophylline)
- Short-Acting
- Inhaled Beta-2 Agonists (Albuterol, Bitolterol, Levalbuterol, Pirbuterol)

To be included in the numerator, patient must have a nondiscontinued prescription for primary asthma therapy (see list of medications below) during the report period.

Primary asthma therapy medication codes for numerator defined with medication taxonomy: BGP HEDIS PRIMARY ASTHMA MEDS.

Medications are:

- Antiasthmatic Combinations (Dyphylline-Guaifenesin, Guaifenesin-Theophylline, Potassium Iodide-Theophylline)
- Inhaled Steroid Combinations (Budesonide-Formoterol, Fluticasone-Salmeterol)
- Inhaled Corticosteroids (Belclomethasone, Budesonide, Flunisolide, Fluticasone CFC Free, Mometasone, Triamcinolone)
- Lekotriene Modifiers (Montelukast, Zafirlukast, Zileuton)
- Mast Cell Stabilizers (Cromolyn, Nedocromil)
- Methylxanthines (Aminophylline, Dyphylline, Oxtriphylline, Theophylline)

If the patient does not have asthma, the following text displays: “This section only reports on people who have asthma. You do not have asthma, so you are not included in this report. If you think you have asthma, talk to your doctor.”

If the patient has asthma and at least one dispensed prescription for primary asthma therapy medication within the last year the following text displays: “This reports looks to see if you were prescribed a medicine for your asthma. You were prescribed at least one medication for your asthma.”

If the patient has asthma and had at least one dispensed prescription for primary asthma therapy medication during the report period the following text displays: “This reports looks to see if you were prescribed a medicine for your asthma. You were not prescribed any asthma medications this year. Talk to your doctor about what asthma treatment, if any, is best for you.”

Example of Quality of Care Transparency Report Card

```
Quality of Care Transparency Report Card - This report looks at five
quality measures. This report card enables you to compare your
personal results to those on the IHS Quality of Care website at:
http://www.ihs.gov/transparency. Your personal information is listed
below.

Diabetes and Glycemic (A1c) Control
Your A1c value on Oct 07, 2008 was NORMAL. The A1c goal for this
report is less than 9%. The IHS goal is less than 7%.

Diabetes and BP Control
Your Blood Pressure was not checked in the past year. You should
have your Blood Pressure checked at least three times a year.

Diabetes and LDL Control
Your LDL was not checked in the past year. You should have your LDL
checked at least once a year.

Flu Shot (Influenza) Vaccine
This section only reports on people who are 50 years of age or
older. You are younger than 50, so you are not included in this
report.

Asthma Medication Status
This reports looks to see if you were prescribed a medicine for your
asthma. You were not prescribed any asthma medications this year.
Talk to your doctor about what asthma treatment, if any, is best for
you.
```

Figure H- 20: Example of Quality Care Transparency Report Card component

Appendix I: Anticoagulation Supplement Logic

The Anticoagulation Supplement is available for patients who have a POV in the last year (365 days) with a diagnosis from BJPCAC THRPY INDICDXS.

The following fields are included in the supplement.

Field Name	Description	Logic Source
Report Date:	Today's Date in mm/dd/yyyy format (Left Justified)	System Generated
Page:	Pages numbered sequentially (Same line to the right of Report Date)	System Generated
Patient's Name	Last, First, Middle Initial (Left Justified)	Pt Reg
HRN	Numeric (Same line to the right of Name)	Pt Reg
Sex:	M or F (Left Justified)	Pt Reg
DOB:	Date of Birth in mm/dd/yyyy format (Same line to the right of Sex)	Pt Reg
Age	Number followed by D or M or Y (Same line to the right of DOB	Pt Reg
Designated Primary Care Provider	Last, First (Left Justified)	DSPM
Indication for Anticoagulation Therapy:	ICD Code; ICD Narrative; Date (Indent 5 spaces under the Display Label)	Most recent of each unique diagnosis within the taxonomy [BJPC INDICATIONS FOR AC THERAPY] . Display most recent first Do not display duplicates
INR Goal:	Display range value (e.g. 2.0 - 3.0; 2.5 - 3.5 or User Defined minimum and maximum values) (Left Justified)	If multiple entries, display the most recent INR Goal range value found in the PCC V-Anti-Coagulation file
Duration of Anticoagulation Therapy	Display value (e.g. 3 months; 6 months; 12 months or Indefinitely (Left Justified)	If multiple entries, display the most recent Duration of Anticoagulation Therapy value found in the PCC V-Anti-Coagulation file
Duration of Anti-Coagulation Therapy Start Date	Date in mm/dd/yyyy format (Indent 5 spaces under the Duration of Therapy line)	If multiple entries, display the most recent Duration of Anticoagulation Therapy Start Date value found in the PCC V-Anti-Coagulation file
Duration of Anti-Coagulation Therapy End Date	Date in mm/dd/yyyy format (Indent 5 spaces under the Duration of Therapy Start Date line)	If multiple entries, display the most recent Duration of Anticoagulation Therapy End Date value found in the PCC V-Anti-Coagulation file

Field Name	Description	Logic Source
ANTICOAGULATION CLINIC VISITS (LAST 100 DAYS)	Date of visit; Visit Provider	V POV List all visits with D1 clinic code beginning with most recent visit and then for the past 100 days ([Today's date]-100 days) See definition AC 8.0
INR VALUES AND MEDICATIONS: (Last 100 Days)	Column 1–Date of INR; Column 2–INR Value; Column 3–Active Warfarin dose (on the date of the INR); Sig; Days Supplied; Column 4–Ordering Provider (Left Justified– 4 columns)	PCC V lab and V med Look first for INR value and then for renewal or change in Warfarin prescription. Display most recent first and then for the past 100 days ([today's date]-100 days)
MOST RECENT RELATED LAB TESTS:	Column 1–Date of Lab Test Column 2–Name of Lab Test Column 3–Complete Results (Left Justified–3 columns)	PCC V lab Find most recent Urinalysis(UA); Complete Blood Count (CBC); and/or Fecal Occult Blood Test(FOBT) Urinalysis defined as: [DM AUDIT URINALYSIS LOINC] and [DM AUDIT URINALYSIS TAX] See Definition AC 3.0 CBC defined as: [BGP CBC CPTS] and [BGP CBC LOINC] and [BGP CBC TESTS] See Definition AC 4.0 FOBT defined as: [BGP FOBT DXS] and [BGP FOBT CPTS] and [BGP FOBT LOINC] and [BGB GPRA FOB TESTS] See Defintion AC 5.0
VITAMIN K PRESCRIBED IN THE PAST YEAR	Column 1–Date Filled Column 2–Vitamin K Dos; Sig Column 3–Ordering Provider (Left justified - all on one line)	V-Med Display all Vitamin K (Phytonadione) prescriptions for the past year ([today's date]-365 days)
PATIENT EDUCATION RELATED TO ANTI-COAGULATION IN THE PAST YEAR	Column 1–Date Column 2–Topic and Sub-Topic (e.g. ACC–C) Column 3–Provider (Left Justified - 3 columns)	V Patient Education Display any patient education entries containing "AC" occurring in the past year ([today's date]-365 days)

Below is an example of an Anticoagulation Supplement:

```
******* CONFIDENTIAL PATIENT INFORMATION -- 12/29/2009 2:57 PM [LAF]
*******
     ANTICOAGULATION PATIENT CARE SUPPLEMENT
Report Date: Dec 29, 2009           Page 1
```

```
Patient's Name: DEMO, PATIENT1     HRN: 111
Sex: M  DOB: Feb 19, 1958  Age: 51
DESIGNATED PRIMARY CARE PROVIDER: SMITH,BENITA

Indication for Anticoagulation Therapy:

INR Goal  2.5 - 3.5
 Duration of Anticoagulation Therapy     3 MONTHS
 Duration of Anticoagulation Therapy Start Date   09/15/2009
 Duration of Anticoagulation Therapy End Date   12/14/2009

ANTICOAGULATION CLINIC VISITS (LAST 100 DAYS):
No Anticoagulation clinic visits on file in the past 100 days

INR VALUES AND MEDICATIONS: (LAST 100 DAYS)
Date  INR Value Medication        Provider
11/24/2009    WARFARIN 4MG TAB Qty: 30 Days: 30  QVPROVIDER,BONN

MOST RECENT RELATED LAB TESTS:
Date   Test        Results
11/24/2009 CPT: 81002 URINALYSIS NONAUTO W/O SCOPE

11/24/2009 CPT: 85027 COMPLETE CBC, AUTOMATED

11/24/2009 CPT: 82274 ASSAY TEST FOR BLOOD, FECAL

VITAMIN K PRESCRIPTION IN THE PAST YEAR:
Date   Medication/Sig      Provider
No Vitamin K medications dispensed in the past 365 days

PATIENT EDUCATION RELATED TO ANTICOAGULATION IN THE PAST YEAR:
Date   Topic        Provider
```

Figure I-1: Example of Anticoagulation Supplement

Appendix J: RPMS Rules of Behavior

The Resource and Patient Management (RPMS) system is a United States Department of Health and Human Services (HHS), Indian Health Service (IHS) information system that is ***FOR OFFICIAL USE ONLY***. The RPMS system is subject to monitoring; therefore, no expectation of privacy shall be assumed. Individuals found performing unauthorized activities are subject to disciplinary action including criminal prosecution.

All users (Contractors and IHS Employees) of RPMS will be provided a copy of the Rules of Behavior (RoB) and must acknowledge that they have received and read them prior to being granted access to a RPMS system, in accordance IHS policy.

- For a listing of general ROB for all users, see the most recent edition of *IHS General User Security Handbook* (SOP 06-11a).
- For a listing of system administrators/managers rules, see the most recent edition of the *IHS Technical and Managerial Handbook* (SOP 06-11b).

Both documents are available at this IHS Web site: http://security.ihs.gov/.

The ROB listed in the following sections are specific to RPMS.

J.1 All RPMS Users

In addition to these rules, each application may include additional RoBs that may be defined within the documentation of that application (e.g., Dental, Pharmacy).

J.1.1 Access

RPMS users shall

- Only use data for which you have been granted authorization.
- Only give information to personnel who have access authority and have a need to know.
- Always verify a caller's identification and job purpose with your supervisor or the entity provided as employer before providing any type of information system access, sensitive information, or nonpublic agency information.
- Be aware that personal use of information resources is authorized on a limited basis within the provisions *Indian Health Manual* Part 8, "Information Resources Management," Chapter 6, "Limited Personal Use of Information Technology Resources."

RPMS users shall not

- Retrieve information for someone who does not have authority to access the information.

- Access, research, or change any user account, file, directory, table, or record not required to perform their *official* duties.
- Store sensitive files on a PC hard drive, or portable devices or media, if access to the PC or files cannot be physically or technically limited.
- Exceed their authorized access limits in RPMS by changing information or searching databases beyond the responsibilities of their jobs or by divulging information to anyone not authorized to know that information.

J.1.2 Information Accessibility

RPMS shall restrict access to information based on the type and identity of the user. However, regardless of the type of user, access shall be restricted to the minimum level necessary to perform the job.

RPMS users shall

- Access only those documents they created and those other documents to which they have a valid need-to-know and to which they have specifically granted access through an RPMS application based on their menus (job roles), keys, and FileMan access codes. Some users may be afforded additional privileges based on the functions they perform, such as system administrator or application administrator.
- Acquire a written preauthorization in accordance with IHS policies and procedures prior to interconnection to or transferring data from RPMS.

J.1.3 Accountability

RPMS users shall

- Behave in an ethical, technically proficient, informed, and trustworthy manner.
- Log out of the system whenever they leave the vicinity of their personal computers (PCs).
- Be alert to threats and vulnerabilities in the security of the system.
- Report all security incidents to their local Information System Security Officer (ISSO)
- Differentiate tasks and functions to ensure that no one person has sole access to or control over important resources.
- Protect all sensitive data entrusted to them as part of their government employment.
- Abide by all Department and Agency policies and procedures and guidelines related to ethics, conduct, behavior, and information technology (IT) information processes.

J.1.4 Confidentiality

RPMS users shall

- Be aware of the sensitivity of electronic and hard copy information, and protect it accordingly.
- Store hard copy reports/storage media containing confidential information in a locked room or cabinet.
- Erase sensitive data on storage media prior to reusing or disposing of the media.
- Protect all RPMS terminals from public viewing at all times.
- Abide by all Health Insurance Portability and Accountability Act (HIPAA) regulations to ensure patient confidentiality.

RPMS users shall not

- Allow confidential information to remain on the PC screen when someone who is not authorized to that data is in the vicinity.
- Store sensitive files on a portable device or media without encrypting.

J.1.5 Integrity

RPMS users shall

- Protect their systems against viruses and similar malicious programs.
- Observe all software license agreements.
- Follow industry standard procedures for maintaining and managing RPMS hardware, operating system software, application software, and/or database software and database tables.
- Comply with all copyright regulations and license agreements associated with RPMS software.

RPMS users shall not

- Violate federal copyright laws.
- Install or use unauthorized software within the system libraries or folders.
- Use freeware, shareware, or public domain software on/with the system without their manager's written permission and without scanning it for viruses first.

J.1.6 System Logon

RPMS users shall

- Have a unique User Identification/Account name and password.

- Be granted access based on authenticating the account name and password entered.
- Be locked out of an account after five successive failed login attempts within a specified time period (e.g., one hour).

J.1.7 Passwords

RPMS users shall

- Change passwords a minimum of every 90 days.
- Create passwords with a minimum of eight characters.
- If the system allows, use a combination of alpha-numeric characters for passwords, with at least one uppercase letter, one lower case letter, and one number. It is recommended, if possible, that a special character also be used in the password.
- Change vendor-supplied passwords immediately.
- Protect passwords by committing them to memory or store them in a safe place (do not store passwords in login scripts or batch files).
- Change passwords immediately if password has been seen, guessed, or otherwise compromised, and report the compromise or suspected compromise to their ISSO.
- Keep user identifications (IDs) and passwords confidential.

RPMS users shall not

- Use common words found in any dictionary as a password.
- Use obvious readable passwords or passwords that incorporate personal data elements (e.g., user's name, date of birth, address, telephone number, or social security number; names of children or spouses; favorite band, sports team, or automobile; or other personal attributes).
- Share passwords/IDs with anyone or accept the use of another's password/ID, even if offered.
- Reuse passwords. A new password must contain no more than five characters per eight characters from the previous password.
- Post passwords.
- Keep a password list in an obvious place, such as under keyboards, in desk drawers, or in any other location where it might be disclosed.
- Give a password out over the phone.

J.1.8 Backups

RPMS users shall

- Plan for contingencies such as physical disasters, loss of processing, and disclosure of information by preparing alternate work strategies and system recovery mechanisms.
- Make backups of systems and files on a regular, defined basis.
- If possible, store backups away from the system in a secure environment.

J.1.9 Reporting

RPMS users shall

- Contact and inform their ISSO that they have identified an IT security incident and begin the reporting process by providing an IT Incident Reporting Form regarding this incident.
- Report security incidents as detailed in the *IHS Incident Handling Guide* (SOP 05-03).

RPMS users shall not

- Assume that someone else has already reported an incident. The risk of an incident going unreported far outweighs the possibility that an incident gets reported more than once.

J.1.10 Session Timeouts

RPMS system implements system-based timeouts that back users out of a prompt after no more than 5 minutes of inactivity.

RPMS users shall

- Utilize a screen saver with password protection set to suspend operations at no greater than 10 minutes of inactivity. This will prevent inappropriate access and viewing of any material displayed on the screen after some period of inactivity.

J.1.11 Hardware

RPMS users shall

- Avoid placing system equipment near obvious environmental hazards (e.g., water pipes).
- Keep an inventory of all system equipment.
- Keep records of maintenance/repairs performed on system equipment.

RPMS users shall not

- Eat or drink near system equipment.

J.1.12 Awareness

RPMS users shall

- Participate in organization-wide security training as required.
- Read and adhere to security information pertaining to system hardware and software.
- Take the annual information security awareness.
- Read all applicable RPMS manuals for the applications used in their jobs.

J.1.13 Remote Access

Each subscriber organization establishes its own policies for determining which employees may work at home or in other remote workplace locations. Any remote work arrangement should include policies that

- Are in writing.
- Provide authentication of the remote user through the use of ID and password or other acceptable technical means.
- Outline the work requirements and the security safeguards and procedures the employee is expected to follow.
- Ensure adequate storage of files, removal, and nonrecovery of temporary files created in processing sensitive data, virus protection, and intrusion detection, and provide physical security for government equipment and sensitive data.
- Establish mechanisms to back up data created and/or stored at alternate work locations.

Remote RPMS users shall

- Remotely access RPMS through a virtual private network (VPN) whenever possible. Use of direct dial in access must be justified and approved in writing and its use secured in accordance with industry best practices or government procedures.

Remote RPMS users shall not

- Disable any encryption established for network, internet, and Web browser communications.

J.2 RPMS Developers

RPMS developers shall

- Always be mindful of protecting the confidentiality, availability, and integrity of RPMS when writing or revising code.
- Always follow the IHS RPMS Programming Standards and Conventions (SAC) when developing for RPMS.
- Only access information or code within the namespaces for which they have been assigned as part of their duties.
- Remember that all RPMS code is the property of the U.S. Government, not the developer.
- Not access live production systems without obtaining appropriate written access, and shall only retain that access for the shortest period possible to accomplish the task that requires the access.
- Observe separation of duties policies and procedures to the fullest extent possible.
- Document or comment all changes to any RPMS software at the time the change or update is made. Documentation shall include the programmer's initials, date of change, and reason for the change.
- Use checksums or other integrity mechanism when releasing their certified applications to assure the integrity of the routines within their RPMS applications.
- Follow industry best standards for systems they are assigned to develop or maintain, and abide by all Department and Agency policies and procedures.
- Document and implement security processes whenever available.

RPMS developers shall not

- Write any code that adversely impacts RPMS, such as backdoor access, "Easter eggs," time bombs, or any other malicious code or make inappropriate comments within the code, manuals, or help frames.
- Grant any user or system administrator access to RPMS unless proper documentation is provided.
- Release any sensitive agency or patient information.

J.3 Privileged Users

Personnel who have significant access to processes and data in RPMS, such as, system security administrators, systems administrators, and database administrators, have added responsibilities to ensure the secure operation of RPMS.

Privileged RPMS users shall

- Verify that any user requesting access to any RPMS system has completed the appropriate access request forms.
- Ensure that government personnel and contractor personnel understand and comply with license requirements. End users, supervisors, and functional managers are ultimately responsible for this compliance.
- Advise the system owner on matters concerning information technology security.
- Assist the system owner in developing security plans, risk assessments, and supporting documentation for the certification and accreditation process.
- Ensure that any changes to RPMS that affect contingency and disaster recovery plans are conveyed to the person responsible for maintaining continuity of operations plans.
- Ensure that adequate physical and administrative safeguards are operational within their areas of responsibility and that access to information and data is restricted to authorized personnel on a need-to-know basis.
- Verify that users have received appropriate security training before allowing access to RPMS.
- Implement applicable security access procedures and mechanisms, incorporate appropriate levels of system auditing, and review audit logs.
- Document and investigate known or suspected security incidents or violations and report them to the ISSO, Chief Information Security Officer (CISO), and systems owner.
- Protect the supervisor, superuser, or system administrator passwords.
- Avoid instances where the same individual has responsibility for several functions (i.e., transaction entry and transaction approval).
- Watch for unscheduled, unusual, and unauthorized programs.
- Help train system users on the appropriate use and security of the system.
- Establish protective controls to ensure the accountability, integrity, confidentiality, and availability of the system.
- Replace passwords when a compromise is suspected. Delete user accounts as quickly as possible from the time that the user is no longer authorized system. Passwords forgotten by their owner should be replaced, not reissued.
- Terminate user accounts when a user transfers or has been terminated. If the user has authority to grant authorizations to others, review these other authorizations. Retrieve any devices used to gain access to the system or equipment. Cancel logon IDs and passwords, and delete or reassign related active and backup files.

- Use a suspend program to prevent an unauthorized user from logging on with the current user's ID if the system is left on and unattended.
- Verify the identity of the user when resetting passwords. This can be done either in person or having the user answer a question that can be compared to one in the administrator’s database.
- Shall follow industry best standards for systems they are assigned to, and abide by all Department and Agency policies and procedures.

Privileged RPMS users shall not

- Access any files, records, systems, etc., that are not explicitly needed to perform their duties.
- Grant any user or system administrator access to RPMS unless proper documentation is provided.
- Release any sensitive agency or patient information.

Glossary

Caret (^)

A circumflex, also known as a “hat” or “up-hat,” that is primarily used for exiting a task. The up-hat is denoted as “^” (caret) and is typed by simultaneously pressing SHIFT+6 on the keyboard.

CHR

A Community Health Representative is a healthcare staff member who provides healthcare services within the community.

Component

A segment of the Health Summary that groups data into sections.

Device

A printer, video terminal, or other type of hardware or equipment associated with a computer. The Health Summary system will prompt you to specify a particular device on which to generate output.

Evoking Codes

Codes recorded on a patient’s problem list that triggers specific data to print in the Health Summary. For example, a diabetic flowsheet will contain evoking codes so that it prints only in the Health Summary of a patient who has a code for diabetes in the Problem List.

Flowsheet

A tabular format for organizing and displaying data in a special section of the Health Summary.

Health Summary

A summary of a patient’s demographic and clinical information compiled from information in the Patient Care Component (PCC) database of the Resource and Patient Management System.

ICD

International Classification of Diseases

ICD codes

A set of numeric codes used in the healthcare industry to label and classify various diseases and health problems. (See ICD.)

Key

A means of securing menus to limit access. To use certain functions, such as those on a manager's menu, the user must be assigned the appropriate key by the site manager.

Menu

A list of choices (see Option) for computing activity presented on the screen for the user to select.

Mnemonic

Two- to four-letter designations used to select menu options and enter data that facilitate these tasks by reducing the number of required keystrokes.

Option

As an item on a menu, an option provides an opportunity for users to select it, thereby invoking the associated computing activity.

OTC

Over-the-Counter is a reference to medications that may be purchased without a prescription.

Panel

A tabular format for presenting a series of clinical measurements or results in the Health Summary.

Patient Care Component (PCC)

The central repository for data in the Resource and Patient Management System.

Problem List

A list of health problems, related notes, and treatment plans for a patient that are recorded and updated as part of the patient's health record.

Queuing

Requesting that a job be processed at a later time rather than in the current session.

ENTER Key

Also known as the RETURN key, this key on the computer keyboard tells the computer to execute a command or store the information typed.

RPMS

The Resource and Patient Management System is the set of computer programs used for managing data at the Indian Health Service.

Submenu

A menu which is underlying or accessible from a primary menu. (See Menu) A software program typically contains a single primary menu and many submenus.

Contact Information

If you have any questions or comments regarding this distribution, please contact the OIT Help Desk (IHS).

Phone: (505) 248-4371 or (888) 830-7280 (toll free)

Fax: (505) 248-4363

Web: http://www.ihs.gov/GeneralWeb/HelpCenter/Helpdesk/index.cfm

Email: support@ihs.gov