

Document Depression Screening and Follow-up Plan using iKnowMed's Patient History Tab

In this lesson, you will learn the required documentation steps for the **MIPS# 134 Preventive Care Screening for Depression and Follow-Up Plan** quality measure using the **Patient History Tab Depression Screening tool**.

- **Depression screening results must be entered on the date of the qualifying visit.**
- If positive, the follow-up plan **MUST** be provided for and discussed with the patient during the qualifying encounter and included in the visit notes. **Follow up plan must be entered into iKM using "Add Depression Status" in Observation tab on the date of the qualifying visit or no later than 2 days following the visit.**
- Depression screening must be completed on the date of the **qualifying encounter or within 14 days prior** to the qualifying encounter.
 - If you elect to screen prior to the office visit date, must document the screening result **on the date of the visit**. If the outcome is positive, the follow up plan must be entered into iKM using the **"Add Depression Status" in Observation on the date of the visit or no later than 2 days following the visit**.
- If the patient **refuses screening**, the documentation must be entered on the **date of the encounter or no later than 2 days following the visit**.

Exclusions:

- Patients with a previous diagnosis of bipolar are excluded from the measure. This can be an active or inactive diagnosis included in the problem list prior to the qualifying visit.
- Note: if a patient is diagnosed with bipolar at the qualifying visit, a documented follow-up plan is required for that visit.



Suicide Risk Assessment alone does not meet the numerator requirement as a valid follow-up plan. If it is checked with no other action plan selected, a confirmation pop-up will be displayed when you click **SAVE**, warning that this plan alone **does not meet the MIPS program requirements**.

iKnowMedSM Generation 2

The screenshot shows the iKnowMed Generation 2 interface for a patient named Quincy Hart (70 / M). The 'Clinical Profile' tab is selected, and the 'Patient Hx' section is visible. The 'Depression Screening & Plan' tool is highlighted in the left sidebar. Red boxes and numbers 1-3 indicate the steps to access the tool: 1. Click on the Clinical Profile tab, 2. Go to the Patient History Tab, 3. Click on the Depression Screening & Plan in the menu.

1. Click on the **Clinical Profile** tab
2. Go to the Patient History Tab
3. Click on the Depression Screening & Plan in the menu

The screenshot shows the 'Depression Screening & Plan' tool interface. The 'Assessment' section is active, and the 'PHQ-9' tool is selected. The 'Observation Date' is set to 01/27/2025. The assessment questions are listed, and the 'Not at all' radio button is selected for the first question. Red boxes and numbers 4-7 indicate the steps to complete the assessment: 4. Indicate which screening tool is being used, PHQ-2 or PHQ-9 by clicking on the tool name. In this example, we are documenting a PHQ-9. 5. Use the calendar widget to add the date of the screening visit. 6. Using the appropriate radio buttons, enter the patient's responses to each question. 7. If an incorrect radio button is clicked, it may be cleared by clicking on the blue clear.

	Not at all	Several days	More than half the days	Nearly every day	
1. Little interest or pleasure in doing things	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	clear
2. Feeling down, depressed, or hopeless	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	clear
3. Trouble falling or staying asleep, or sleeping too much	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	clear
4. Feeling tired or having little energy	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	clear
5. Poor appetite or overeating	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	clear
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	clear
7. Trouble concentrating on things, such as reading the	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	clear

4. Indicate which screening tool is being used, **PHQ-2 or PHQ-9** by clicking on the tool name. In this example, we are documenting a PHQ-9.
5. Use the calendar widget to add the **date of the screening visit**.
6. Using the appropriate radio buttons, enter the **patient's responses to each question**.
7. If an incorrect radio button is clicked, it may be cleared by clicking on the blue clear.

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8. A PHQ-2 may also be documented.

9. Enter any optional comments in the comments box, if desired.

10. The results box will display the screening score, tool used, depression severity, and if a plan is needed. As shown here, if the screening is positive, the box will turn pink, indicating positive depression screening result.

Note: If positive, a follow-up plan must be shared with the patient on the date of the visit and documented within 2 days of the screening visit.

11. The date will default to the current day or use the calendar widget to select the date of follow up plan documentation. **The date of the follow up plan is required to be documented and must be no later than 2 days after the EM screening visit.**

12. Using the radio buttons, document the follow up plans.

13. Comments may be added, if desired.

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14. If a plan is not documented, a **(Reminder: Plan Needed)** indicator will appear and the SUBMIT button will be greyed out, as indicated by the arrow.

15. If the patient indicated a positive response to the self-harm question in the PHQ-9, a warning box will display at the top of the screening.

16. Adding the plan date, using the options listed, document the follow-up plan by checking all boxes relevant. **The date of the follow up plan is required to be documented and must be no later than 2 days after the EM screening visit.**

Note: Suicide Risk Assessment by itself does not meet the numerator requirement as a valid follow-up plan. If it is checked with no other action plan selected, a confirmation pop-up will be displayed when you click SAVE, warning that this plan alone does not meet the MIPS program requirements.

17. Click **SUBMIT**.

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18. If the screening is positive and the patient declines treatment, **enter the date of the follow up plan documentation. The date of the follow up plan is required to be documented and must be no later than 2 days after the EM screening visit.**

19. Check the box next to “Patient declined treatment.”

20. To save, click **SUBMIT**.

21. If the screening is negative, the results box will show score and no plan needed.

22. If the patient declines to complete the screening, scroll down under the assessment, before the follow up plan section and check the box “**Patient declined to complete assessment.**”

23. To save, click **SUBMIT**.

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Past Assessments & Plans

Date	Score	Comments	Plan	Plan Comments	Source	Last updated	
01/27/2025	18/27	-	Under current care with a practitioner who is qualified to diagnose and treat depression	Seeing Dr. Radar for counseling since 2023	Practice user	01/27/2025 by Sharon Hart 15:03	EDIT
12/10/2024	24/27	-	Referral to a practitioner who is qualified to diagnose and treat depression; Under current care with a practitioner who is qualified to diagnose and treat depression	-	Practice user	12/10/2024 by Sharon Hart 14:32	EDIT
03/30/2024	4/6	-	Pharmacological interventions	-	Practice user	04/17/2024 by Sharon ZZAlexander 15:09	EDIT
03/28/2024	4/6	-	Pharmacological interventions	-	Practice user	05/16/2024 by Sharon ZZAlexander 14:18	EDIT

24. Past screenings are available at the bottom of the screen.

25. Click **EDIT** to review or revise.

This concludes the lesson on **MIPS# 134 Preventive Care Screening for Depression and Follow-Up Plan** using the iKM Patient History Tab.