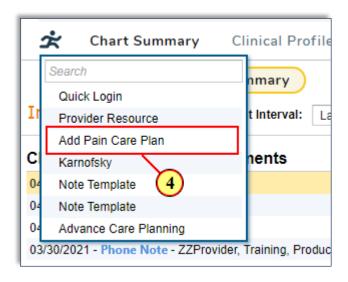
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Documenting A Pain Care Plan

In this lesson you will learn the required documentation for the MIPS #144 Plan of Care for Pain quality measure. A pain care plan must be entered for every qualifying encounter (E/M visit) if pain has been quantified as >0.

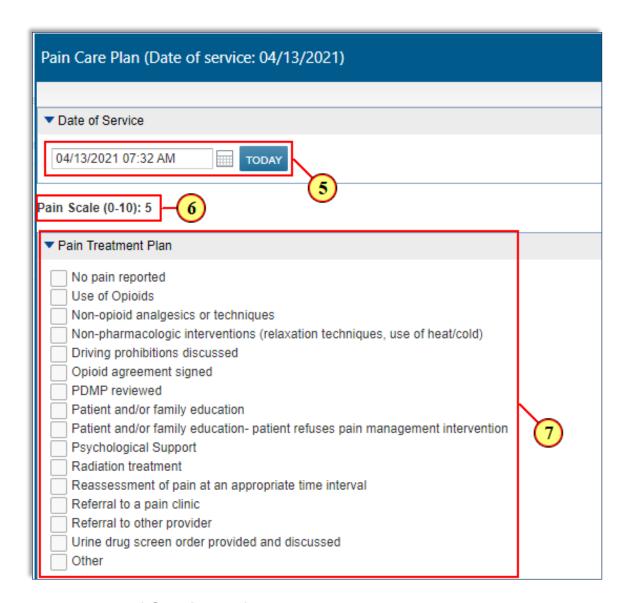


- 1. To add a **Pain Care Plan**, click **ADD CAREPLAN** under **Care Plan** in the patient's **Clinical Profile**.
- 2. The **Pain Care Plan** is also accessible directly from the **Patient Banner**, when expanded. If the **Patient Banner** is not already expanded, click the arrow next to the patient's photo to expand it.
- 3. If the patient's pain is documented at a value greater than 0, the value is red. Click **Pain Scale** to go directly to the patient's **Pain Care Plan**.



4. Alternatively, if you have added it to your **Quick Action Menu**, access the **Pain Care Plan** via the **Running Man**.

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- 5. The **Date of Service** defaults to the current date and time and can be changed by clicking in the field or using the calendar widget.
 - To meet the measure, the plan must be documented on the same date as the qualifying encounter where pain intensity was documented as >0.
- 6. If the **Pain Scale** was documented in the **Vital Signs** area, it is displayed in the **Pain Care Plan**.



The Pain Scale value also displays in the **Patient Banner** when it is expanded.

7. The checkboxes allow you to select all applicable **Pain Treatment Plan** options.

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- 8. Additional Comments can be documented using the provided free text field.
- 9. Click SAVE to add the Pain Care Plan details to the patient chart.



10. Clicking on the Pain Care Plan selects it and enables the **EDIT** and **REMOVE** buttons.

This concludes the lesson for MIPS #144 Plan of Care for Pain.