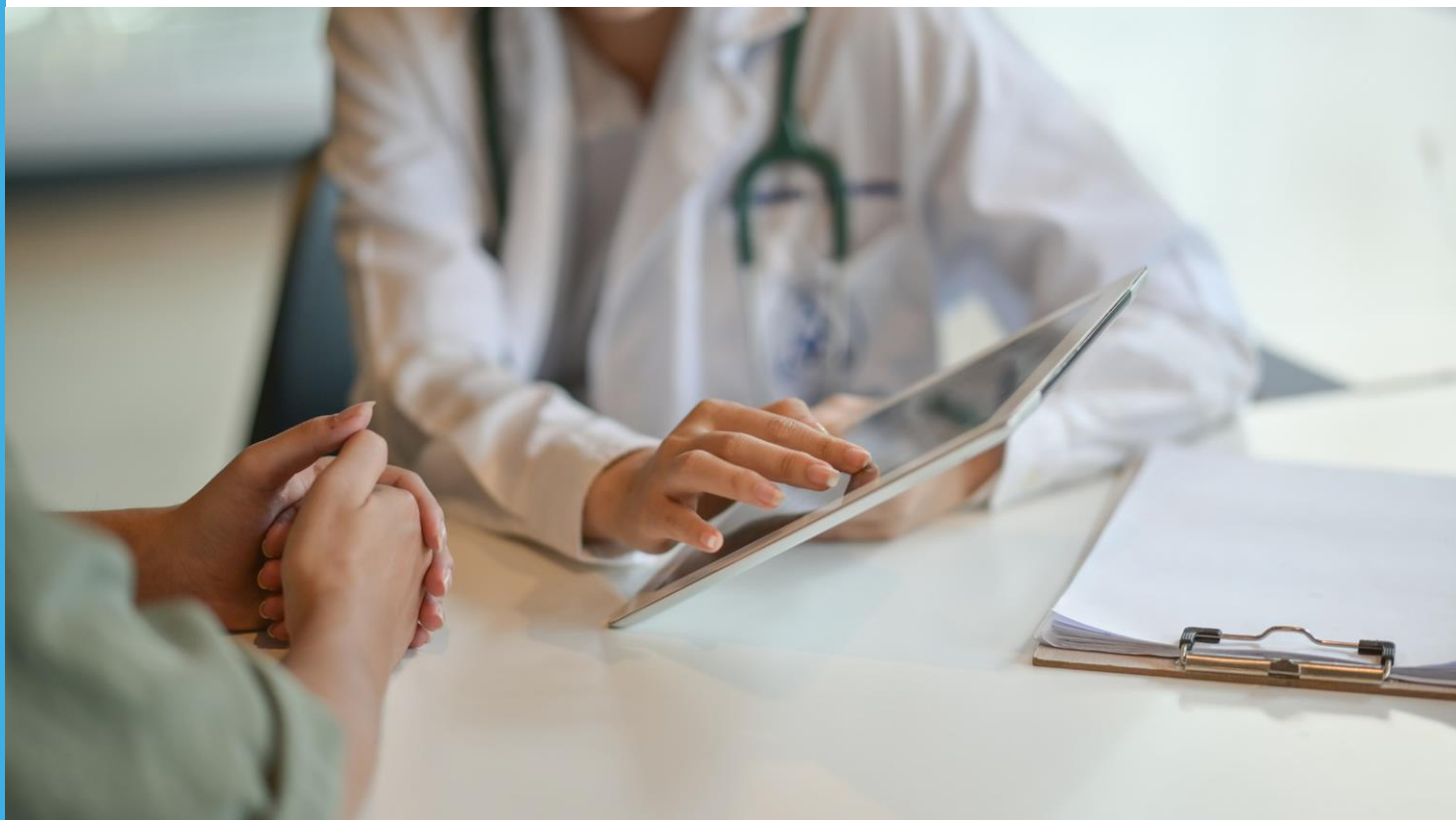


# Major Depression & Anxiety Oracle Toolkit



## Summary

The purpose of this toolkit is to guide Oracle hospitals in Ontario to implement the Evidence2Practice Ontario (E2P) Major Depression & Anxiety use case. The E2P program is a cross-sector collaborative in partnership with North York General Hospital, the Centre for Effective Practice, and Amplify Care. The goal of this program is to provide clinicians with access to digitized evidenced-based tools at the point of care, leading to improvements in the provider and patient experience, clinical outcomes, and care coordination.

This toolkit equips hospitals with guidance for digitizing foundational elements of measurement based care, based on Ontario Health's [Depression Quality Standard](#) and [Anxiety Quality Standard](#). The goal of this documentation is to reduce work effort required by other Oracle hospitals to build and implement these digital enhancements.

## Before You Start

This toolkit can be useful for mental health clinicians, clinical informaticians, and/or project managers who may be involved in reviewing and implementing the PHQ-9, GAD-7, and dashboard at their respective hospitals. The goal surrounding this, is to support improved care for patients experiencing major depression and/or anxiety, by adopting practices aligning with measurement-based care.

Implementation timelines may vary depending on an organization's resources, state of readiness, and health information system (HIS) maturity. The hospitals that implemented the PHQ-9, GAD-7, and trended-scores dashboard went live within 5 months of initiation. Due to the localization of clinical workflows, your organization may find that not all the suggestions in this toolkit apply to you.

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# Implementation Overview

## *Implementation Scope*

Quality standards outline what high-quality care looks like for conditions where there are variations in how care is delivered, or where there are gaps in how patients receive care across Ontario. The standards have Quality Statements that look to address those gaps and describe what high quality care looks like across the broader healthcare continuum (in primary care, acute care, and community care).

One of the goals of Evidence2Practice is to support hospitals in implementing digital enhancements that enable clinicians to deliver on the quality standard. However, not all statements apply to acute care, and the relevance can vary based on the setting (e.g. inpatient, outpatient, emergency department, specialty clinics, etc.). To scope this work, a formal governance group was established with clinical and digital leaders from varying hospitals to outline the initial focus for implementations given typical hospital maturity, resources, and overall timelines for E2P support.

The details below outlines the recommended scope for the E2P program:

- Electronic documentation of the PHQ-9 and GAD-7, two screening tools whose scores can be used to support measurement-based care
- Digital dashboard which can trend these scores overtime, allowing clinicians to see the progress after repeated measurement for a patient with major depression or anxiety and use it to inform decision making
- Enhanced patient and provider after-visit summaries
  - Including aligning patient summaries with the PODs model and ensuring appropriate information is displayed in the provider summaries to support transitions in care

Organizations can implement this in the inpatient setting and/or the outpatient setting, however more benefit may be realized in the outpatient setting due longer program durations, and more points of measurement.

Although the goal is to consistently implement the scope above, the E2P team works with each hospital to customize/localize the implementation to support adoption of measurement-based care within each organization. When considering the scope, the clinical teams would work with E2P to outline their approach and setting (e.g. inpatient/outpatient, and which units/clinics/programs to focus on). Some hospitals elected to take a phase approach with rolling out enhancements, whereas others decided to have a consolidated effort to push out the changes.

### *Mobilize your implementation team*

To successfully implement these digital enhancements, you will need a clinician champion (e.g., psychiatrist, psychologist, social worker), clinical informaticians (e.g., Orders Analyst) and a project lead (e.g., project manager). The clinician champion is best positioned to speak to the importance of measurement-based care tools to their colleagues and will design the clinical workflow. The clinical informaticians will build and customize the digitized PHQ-9 and GAD-7 forms, dashboard, and reports in Epic. The project lead's role is to facilitate discussions and decisions between the clinicians and clinical informaticians – ensuring that the technical design supports the desired clinical workflow.

### *Define the clinical workflow and dashboard layout*

The clinician champion will outline the steps for administering and collecting the PHQ-9 and GAD-7. Although the PHQ-9 and GAD-7 are patient-facing questionnaires, organizations can vary in what systems they have in place to distribute and collect the questionnaires and ensure the data is available in Oracle. Thus, teams would need to discuss and decide on the appropriate workflow (e.g. electronic distribution for patients, transcription into the system in scenarios where patients do not have access to a portal, etc.).

Take this time to also define the content that would be useful for clinicians to see on the trended scores dashboard. The trended scores dashboard is a single view to track and trend the PHQ-9 and GAD-7 across multiple encounters. The E2P program suggests starting with the minimum requirements (e.g., utilizing an HIS functionality that will pull all the documented scores onto one page), and then adding additional useful content based on clinical champion priorities, clinical informatics capacity, and HIS capabilities (e.g. tying medications or interventions to the scores seen on the dashboard).

### *Build the technical components within Epic*

The clinical informaticians will mock-up the PHQ-9, GAD-7 and dashboard within Oracle. During the clinical workflow and content conversations, consider having clinical informaticians present so that they can hear first-hand the desired end state, and also provide feedback on feasibility.

### *Conduct end-user testing and seek feedback*

With each mock-up and new iteration, ensure you are seeking feedback from the end-users for both digital and workflow changes. Appropriate documentation of decisions and updated workflows are essential to support change management and training.

## *Execute change management strategies*

Engage end-users at a broader level (e.g., department meetings, morning huddles) to encourage adoption and utilization of the digital enhancements. The E2P team will work with the organization to create education materials or documentation that supports end-users in finding and using the digital enhancements within Epic.

## The PHQ-9 and GAD-7

### *Background*

The PHQ-9 is a validated tool for assessing the severity of symptoms and degree of functional impairment. It is one component of a comprehensive assessment.<sup>1</sup> Consistent measurement of symptoms using the PHQ-9 allows providers gather data about a patient's depression symptoms, which then informs treatment decisions and care planning. This approach utilizes the PHQ-9 to track symptom severity over time and to facilitate collaborative discussions between clinicians and patients. There are no strict guidelines on how often the PHQ-9 should be re-administered in an inpatient or outpatient setting.<sup>2</sup>

The GAD-7 is both a screening and validated severity-rating tool. By itself, identification does not provide a diagnosis of an anxiety disorder; however, it does provide preliminary documentation of symptoms and quantify severity in a time-limited setting, and it indicates who may need further assessment.<sup>3</sup> The GAD-7 is a validated severity-rating tool that can be used as one component of a comprehensive assessment. The E2P program focuses on the administration of the GAD-7 as it can be used for general anxiety disorder, and often a starting point for measurement-based care in people with other anxiety disorders. The Anxiety Quality Standard has a list of other validated severity-rating tools that can be used for other anxiety disorders in conjunction with the GAD-7.

### *Frequency of Administration*

With input from the Evidence2Practice Ontario Topic Expert Group and the initial pilot site hospitals, the E2P program recommends that the PHQ-9 and GAD-7 be completed at least once every six weeks. There are no strict guidelines on how frequently these scales should be readministered, but there is some guidance on re-administering the PHQ-9 at 4-6 weeks to measure response to treatment.<sup>2</sup> Therefore, the E2P program suggests that in the outpatient setting, the PHQ-9 and GAD-7 be re-administered at 4-6 weeks-in accordance with organizational policies and clinical judgment. For the inpatient setting, most organizations administer questionnaires early in admission to support screening and baseline documentation. Additional questionnaires have been added to support evaluation of electroconvulsive therapy (ECT).

## Clinical Workflow

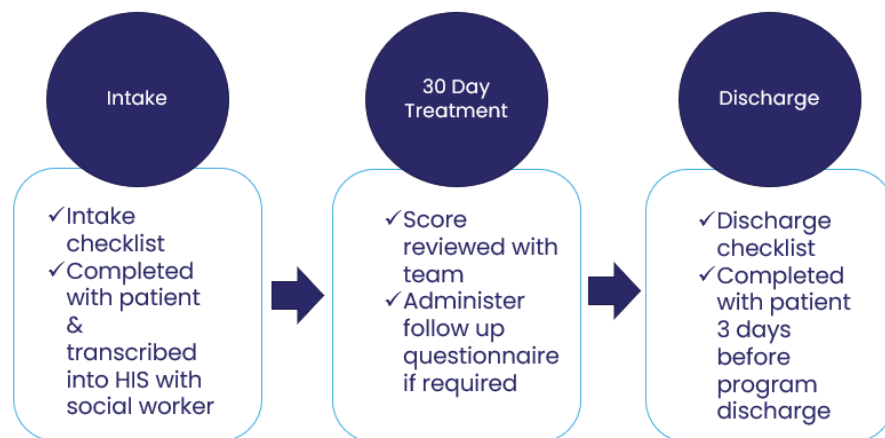
It is expected that the clinical workflows for administering the PHQ-9 and GAD-7 be unique to each organization, but here is an example below:

### Example 1.

#### *Outpatient Mental Health Adult Day Hospital*

*Average treatment cycle: 4 weeks*

*Documentation:* HIS PHQ-9, GAD-7 Flowsheet, transcribed by clinician, score trended by dashboard

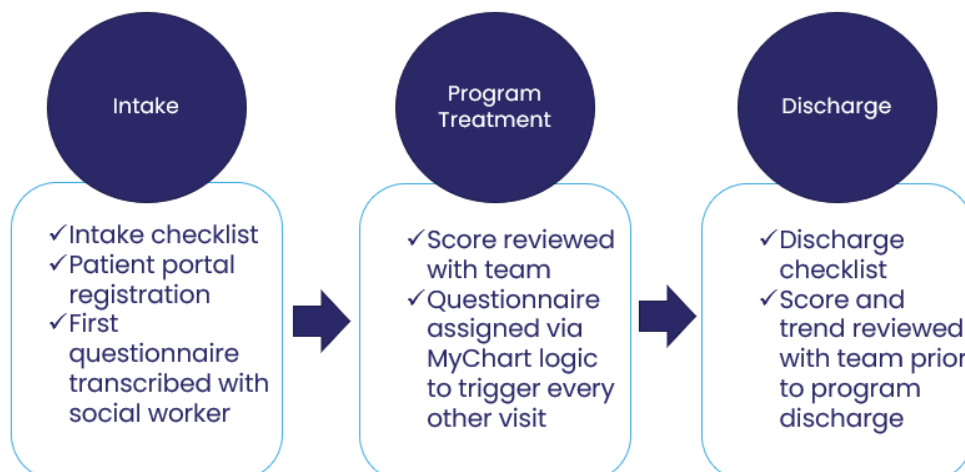


### Example 2.

#### *Outpatient Mental Health Adult Clinic*

*Average treatment cycle: 12 weeks*

*Documentation:* Patient Portal MyChart email distribution 3 days prior to visit for assigned clinicians with email reminder, registration alert if questionnaire incomplete & tablet available for patient documentation, HIS PHQ-9, GAD-7 Flowsheet available for transcription, score trended by dashboard.





### Example 3.

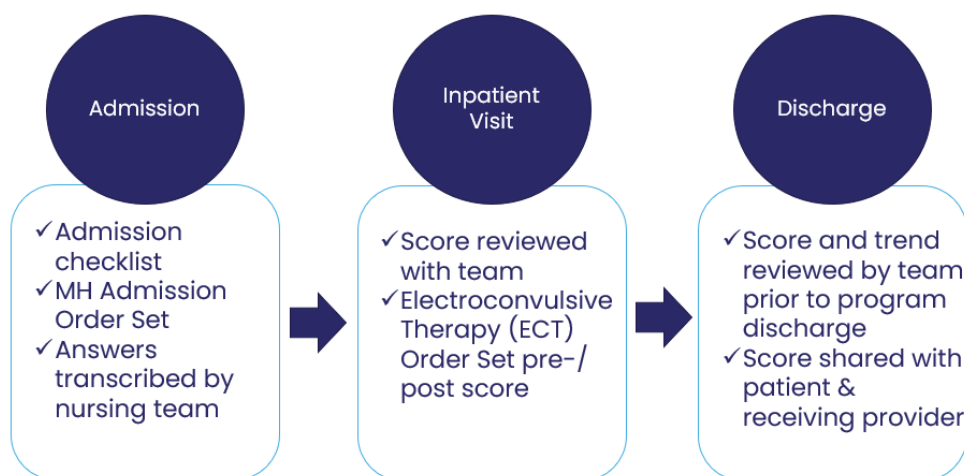
#### *Inpatient Adult & Geriatric Mental Health Units*

*Average length of stay: <10 days*

*Documentation:* PHQ-9/GAD-7 answers transcribed by MH RN/RPN into HIS flowsheet. PHQ-9/GAD-7 flowsheet available under nursing admission/assessment/discharge flowsheets to reduce navigation. PHQ-9/GAD-7 documentation score can be viewed on nurse worklist and global results review to support discussion during rounds.

MH Admission Order Set includes pre-checked PHQ-9/GAD-7 order to promote screening & baseline documentation for all patients (if appropriate).

Electroconvulsive Therapy (ECT) includes pre-checked pre-/post- questionnaire order. MH RN/RPN transcribes answers into HIS flowsheet.



## Trended Scores Dashboard

The purpose of the trended scores dashboard is to support clinicians in using measurement-based care to track the patient's progress on one page. Some examples of how this can be achieved are line graphs that visually display the change in scores, or by having a table that shows the multiple scores for the specific patient. The content and design of the dashboard should be defined by the clinical champion. Some hospitals opted for a one-pager that displayed the scores across multiple encounters and used colours to trigger the most responsible provider to pay attention to high scores. Other hospitals implemented a dashboard that also highlights specific questions related to thoughts about self-harm.



# The Enhanced Patient & Provider Discharge Summary

## *Background*

Through a review of the literature (e.g., [Patient Oriented Discharge Summary Checklist](#)) and consultation with the Evidence2Practice (E2P) Topic Expert Group, 7 Evidence2Practice Anxiety and Depression pilot site organizations, and Patient Family Advisors (PFAs), key principles of a patient and provider discharge summary were identified.

The following key principles of a quality patient and provider discharge summary outline the crucial components of both documents. These elements should be incorporated in the enhanced Patient and Provider Discharge Summary to improve communication with patients and receiving clinicians and enable seamless transitions in care. Note that the following key principles and recommendations were developed through the approach outlined above; hospitals may connect with local PFAs to ensure that enhancements are appropriate.

## Patient Discharge Summary Key Principles

The Patient Discharge Summary must be a comprehensive document with literacy appropriate instructions and patient education materials. A completed Patient Discharge Summary helps patients successfully transition from the outpatient setting. The following elements will need to be incorporated in the Patient Discharge Summary:

### ***Most Important Information at the Top***

To support successful transition, include elements of the discharge that are most important at the top of the document. For example, information about follow-up appointments and/or safety plans should be included first where the patient or support persons can quickly access the information.

### ***Simple Description of the Medical Condition/ Diagnosis***

At the time of discharge, the patient should be provided with a document that explains why they were receiving care. Periods during inpatient or outpatient treatment can be an overwhelming time for patients and having a clear description of the main problem and why the patient was receiving treatment is important.

### ***Medication Reconciliation***

Including an updated list on new, changed, and discontinued medications with a rationale on what these medications are for and/or why they were changed is important for the patient to know upon transitioning home (Transition from Hospital to Home – Quality

Standard) ([source](#)). This is consistent with what is being highlighted in the Patient Oriented Discharge Summary practice guide ([source](#)).

### ***Follow-up Appointments***

Follow up appointments including location, date, time, and a contact number if the patient has any questions about the appointment enables a seamless transition in care (Ontario Health Quality Standard 12: Transitions in Care). In a survey, patients reported that often it is unclear whether they are to call the clinic and book the appointment, or if the clinic will contact them. Sites are encouraged to make this distinction clear in the discharge summary and during the discharge process.

### ***Guidance on How to Manage Condition at Home***

Transitioning to home or other community settings after receiving mental health care will require educational support that focuses on wellness, social support, safety resources, and a crisis and/or relapse prevention plan. This education can be incorporated within the discharge summary, or as a separate pamphlet/booklet. According to E2P Topic Expert Groups (including psychologists, psychiatrists, mental health clinicians, patients with lived experience) and Health Quality Ontario ([source](#)), some key items to include on the discharge documentation and discuss with the patient are:

- Normal expected symptoms, danger signals, and what to do
- Safety/ crisis plan
- Relapse prevention plan
- Pre and post outcome measures [PHQ-9 and GAD-7]
- List of lifestyle changes to be made and timeline to resume normal activity
- Phone numbers, community resources, and online resources

## **Provider Discharge Summary Key Principles**

The primary function of a Provider Discharge Summary is to provide a complete summary of a patient's visit and enable transitions in care by providing a discharge plan to receiving clinicians. This must be distributed in a timely manner to ensure a seamless transition to providers outside the hospital. The following elements must be incorporated in the provider discharge summary:

### ***Date of Admission and Discharge***

According to the primary care provider representatives in the E2P Topic Expert Group, University Health Network (UHN), and a systematic review that looked at optimizing the quality of hospital discharge summaries, an admission date and discharge date are key information to include in the provider discharge summary. This helps inform the receiving clinician on how long the patient's length of stay was and when the patient was discharged from the hospital so subsequent follow up can be arranged in a timely manner.

### ***Primary Discharge Diagnosis***

The E2P Topic Expert Group identified that it is helpful to have one primary discharge diagnosis or most responsible diagnosis clearly highlighted on the discharge document. This is in accordance with suggestions and evidence from UHN and HIM. As per feedback from primary care providers, it is important to have the main discharge diagnosis clearly indicated in the beginning of the Provider Discharge Summary.

### ***Medication Reconciliation***

Literature consistently suggested that a full medication reconciliation is essential to include in the discharge summary. CPSO encourages physicians to include any changes to ongoing medications and the rationale for these changes. This was also echoed by the E2P Topic Expert Group.

### ***Follow-up Plan***

Having a clear follow up plan for the receiving clinician is crucial for a seamless transition in care. UHN suggests an itemized follow up plan with instructions for the receiving clinician, as well as a list of follow up arrangements and referrals scheduled/ to be scheduled. This is echoed by the HIM key principles and CPSO. Safe and effective transitions can be facilitated by standardized communication between settings.

### ***Significant Labs, Diagnostic Imaging, Treatment and Outcome Measures***

Including labs, diagnostic imaging, and pertinent results that are related to the patient's mental health diagnosis and stay in the hospital can help the receiving clinician better understand the admission, care provided, and patient's post discharge needs. E2P recommends scores from validated tools for assessing the severity of symptoms and degree of functional impairment also be added. For example, the GAD-7 and PHQ-9 scores and trends can quantify symptom monitoring for treatment adherence and response.

### ***Implementing Changes to a Patient After Visit Summary and Provider Discharge Summary in Epic***

Modifications were made to the After Visit Summary and Provider Discharge Summary to better align with the key principles. See below for guides on how different elements of the patient-facing and/or provider discharge summaries were modified in Epic to incorporate key principles and other feedback. Please note, you may find that your organization already has certain key principles embedded within your discharge summary templates

## Change Management Strategy

To support change management associated with the implementation, it's important to execute the strategy below alongside implementation. Identifying the current state, the changes to both the system and the subsequent workflow, can help drive the tactics that will support clinicians in feeling comfortable with adopting measurement-based care. The steps below provide an overview of change management principles, and the E2P team will work alongside your team to further detail tactics that work for your organization.

**Step 1. Assessment of Current State:** Conduct a comprehensive assessment of the current mental health assessment procedures at the hospital site. Identify existing assessment tools, workflows, and any challenges or gaps in the current system

**Step 2. Stakeholder Identification and Engagement:** Identify key stakeholders involved in the implementation process, including clinicians, administrators, IT staff, and patient representatives. Engage stakeholders early to gain their buy-in, address concerns, and involve them in decision-making processes. Successful E2P sites have had executive and department leadership (e.g., Chief of Psychiatry, Mental Health Director) included in project activities or acting as project leader.

**Step 3. Identify Overall Vision and Goal Setting.** Develop a clear vision for the integration of PHQ9/GAD7 assessments and measurement-based care, along with specific goals objectives. Communicate the vision and goals to all stakeholders to ensure alignment and commitment to the change process. Successful E2P sites have aligned project activities with their organization's internal priorities such as annual Quality Improvement Plans.

**Step 4. Identify Change Champions:** Identify and empower change champions within the hospital who will advocate for the adoption of measurement-informed care, provide support to peers, and drive adoption across different departments and teams.

**Step 5. Training and Education:** Provide comprehensive training and education sessions for clinicians and staff on the purpose, use, and administration of PHQ9/GAD7 assessments. Ensure that staff are proficient in administering the assessments, interpreting the results accurately, and teaching patients about the purpose of the PHQ9/GAD7.

**Step 6. Workflow Design or Redesign:** Collaborate with clinicians and staff to redesign workflows to incorporate PHQ9/GAD7 assessments seamlessly into existing processes. Ensure that the integration does not disrupt clinical workflows and that assessments are administered at appropriate intervals in the patient care pathway. Successful E2P sites have automated questionnaire distribution where possible via patient portals or aligned with standardized intake/discharge processes.

**Step 7. Technology Implementation:** Work closely with IT staff to implement any necessary devices to support the integration of the PHQ9/GAD7 assessments. This may include deploying tablets to allow for patients to fill out the assessments in the waiting room, or for the clinical staff to easily capture this information when discussing with the patient.

**Step 8. Communication Plan:** Develop a comprehensive communication plan to keep all stakeholders informed and engaged throughout the implementation process. Communicate regularly through various channels, such as standing meetings, email progress updates, address concerns, and celebrate successes.

**Step 9. Monitoring and Evaluation:** Establish metrics and key performance indicators (KPIs) to monitor the success of PHQ9/GAD7 adoption. Continuously evaluate the impact of change on patients, clinician satisfaction, and operational efficiency. Use feedback from stakeholders to identify areas for improvement and make adjustments as needed. See separate reporting toolkit for more information.

*E2P Recommended KPIs- Outpatient*

- Percentage of patients with a registered visit at [outpatient clinic] who received a PHQ-9 in the last 6 weeks. *Denominator:* # of people who had a registered visit at the [outpatient clinic] during the month of reporting. *Numerator:* # of people who received a PHQ-9 at least once in the past 6 weeks.
- Percentage of patients with a registered visit at [outpatient clinic] who received a GAD-7 in the last 6 weeks. *Denominator:* # of people who had a registered visit at the [outpatient clinic] during the month of reporting. *Numerator:* # of people who received a GAD-7 at least once in the past 6 weeks

*E2P Recommended KPIs- Inpatient*

- Percentage of people with major depression or anxiety disorder who receive a minimum of one PHQ-9 during their hospital visit
- Percentage of people with major depression or anxiety disorder who receive a minimum of one GAD-7 during their hospital visit
- Percentage of people with major depression or anxiety who have a patient discharge summary upon transitioning from one care provider to another

- Percentage of people with major depression who have their provider discharge summary completed within 48h of discharge
- Percentage of people with major depression who transition from the inpatient setting to the community who have a booked follow-up appointment with a GP or MH clinician within 7 days of discharge
- Percentage of people with major depression who receive a minimum of two suicide risk assessments during the hospital visit
- Percentage of people with major depression who are offered information regarding community supports or crisis services during their hospital visit

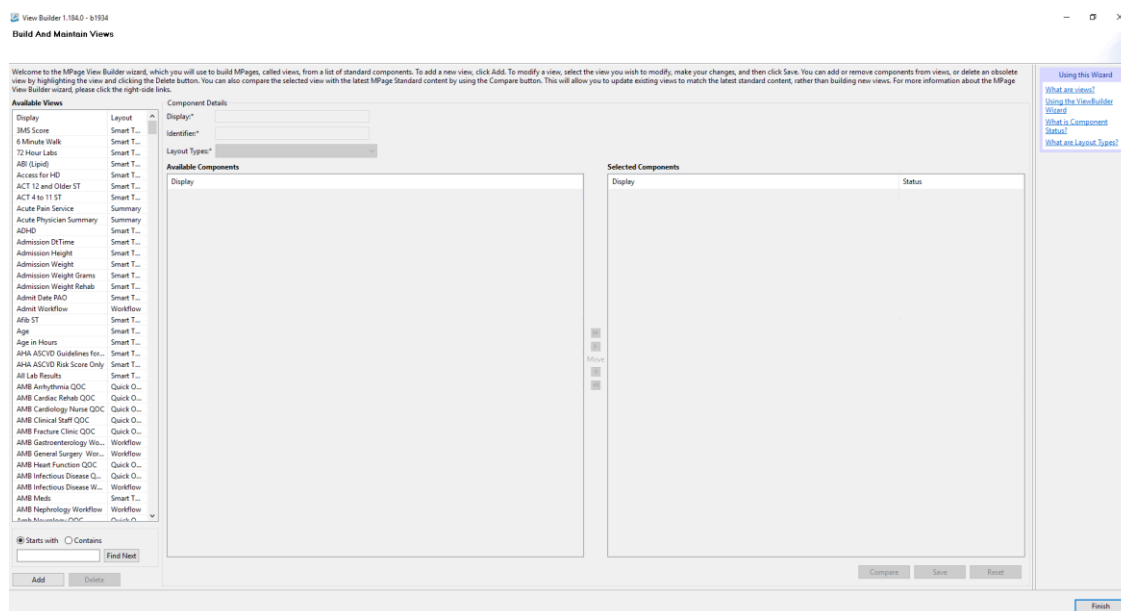
**Step 10. Sustainability and Continuous Improvement.** Develop strategies to ensure the sustainability of measurement-based care in the long term. Successful E2P sites have included the workflow changes into ongoing operations, such as PHQ9/GAD7 clinician training in orientation, standardized intake/discharge checklists, and quarterly metric reporting.

## Technical Build

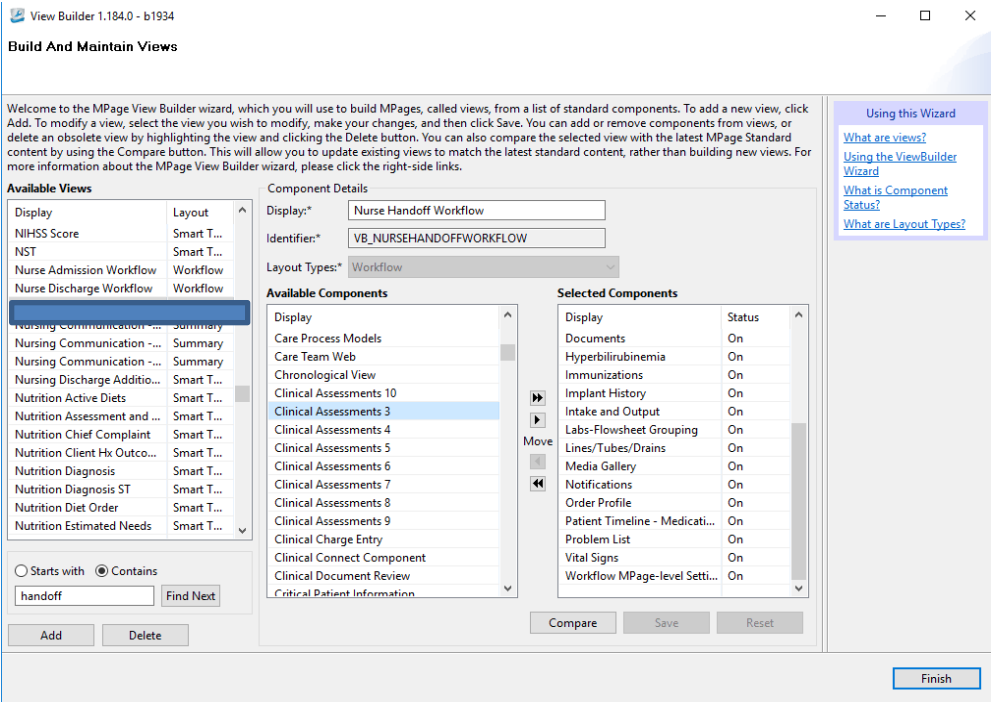
### PHQ-9/GAD-7 Dashboard

Listed below are examples and build steps of how one Oracle hospital built the PHQ-9, GAD-7 dashboard

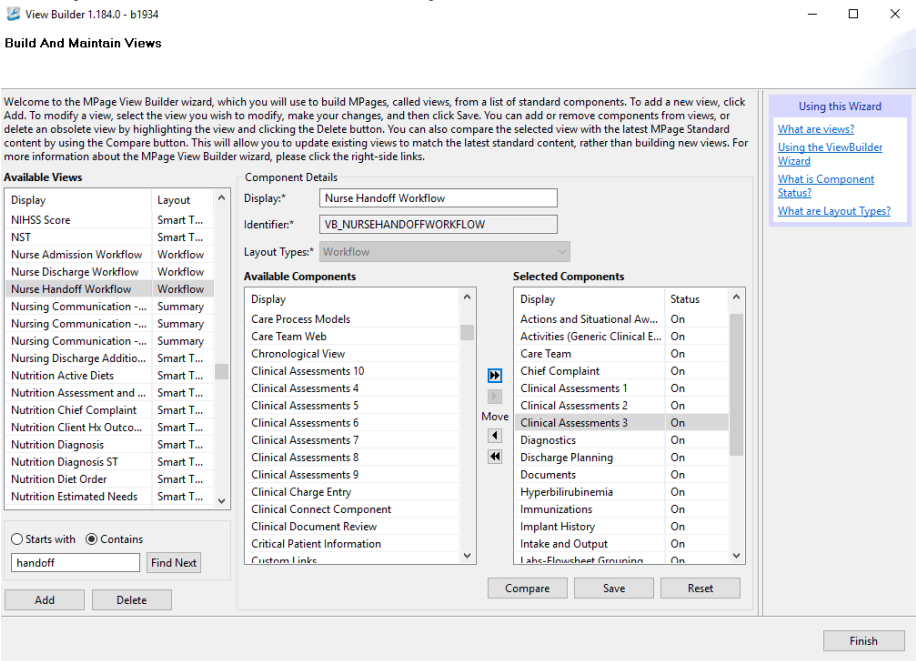
Access Bedrock → Viewbuilder



Select the MPage dashboard will be applied to. Dashboard must be applied to a workflow MPage(s). In this example Nurse Handoff Workflow was chosen.



Move Clinical Assessments (choose lowest number) from available to selected components. In this example Clinical Assessments 3 was chosen. Click Save&Finish



Navigate to Bedrock MPage setup. Load chosen MPage (Nurse Handoff Workflow is used



in this example) Next

- MPages can be customized at the position level. in this example we are updating the default settings by selecting Define default settings.

MPage Setup 1.191.0 - c1934

Select Topic

Select a topic for which you want to define settings.

Search

Starts With Topic name\* nurse handoff Search

Select a topic: Nurse Handoff Workflow View Saved Settings...

For the topic you selected, you can define default, position-specific, or position plus location-specific settings. Default settings will be applied for all users that do not have position-specific or position plus location-specific settings. Default settings must be defined prior to defining settings at the position, or position plus location-specific level.

Define and maintain default settings.

☒ **Define default settings**  
Define and modify default settings

☐ **Define new position or position plus location settings**  
Define settings for specific position or position plus location combinations.

☐ **Modify position or position plus location settings**  
Modify defined settings for a specific position or position plus location combination.

☐ **Copy settings**  
Copy defined settings to specific position or position plus location combinations.

Using this Wizard

- [Defining filters for all components](#)
- [Filter types](#)
- [Learn more about MPages](#)
- [More about defining position-specific settings](#)
- [Defining Position Plus Location-Specific Settings](#)
- [Defining facility-specific settings](#)
- [Removing facility-specific settings](#)
- [Copying facility-specific settings](#)
- [Copying Position Plus Location-Specific Settings](#)
- [More about View Saved Settings](#)

Next Close

## Select Define MPage Layout

MPage Setup 1.184.0 - b1934

Define MPage Parameters

Topic: Nurse Handoff Workflow

For the topic you selected, select a component to view additional information about what the component evaluates. To define the criteria for the filters used to select data for a component, highlight the component in the list and click Begin.

Components

- ▼ Nurse Handoff Workflow
  - Filters for all components
  - Actions and Situational Awareness
  - Activities (Generic Clinical Events)
  - (OBSOLETE) Allergies
  - Care Team
  - Chief Complaint
  - Diagnostics
  - Discharge Planning
  - Documents
  - Intake and Output
  - Labs-Flowsheet Grouping
  - Lines/Tubes/Drains
  - Order Profile
  - Patient Timeline - Medications
  - Vital Signs
  - Workflow MPage-level Settings
  - Hyperbilirubinemia
  - Notifications
  - Immunizations
  - Problem List
  - Clinical Assessments 1
  - Media Gallery
  - Implant History
  - Clinical Assessments 2

Nurse Handoff Workflow

The Neonate view is focused on providing a display of newborn patient specific information

Before using the page, there is some information that you must provide. You'll begin by reviewing the components that are available for this page, and determining if you would prefer to exclude any of them from displaying on the page. Next, you'll have the option to adjust the sequence in which the components will be displayed.

After determining which components will be displayed on the page, you'll be asked for information related to each component. To define the component-level information, select each component and click the Begin button.

To begin, click the Define MPage Layout button.

Define MPage Layout

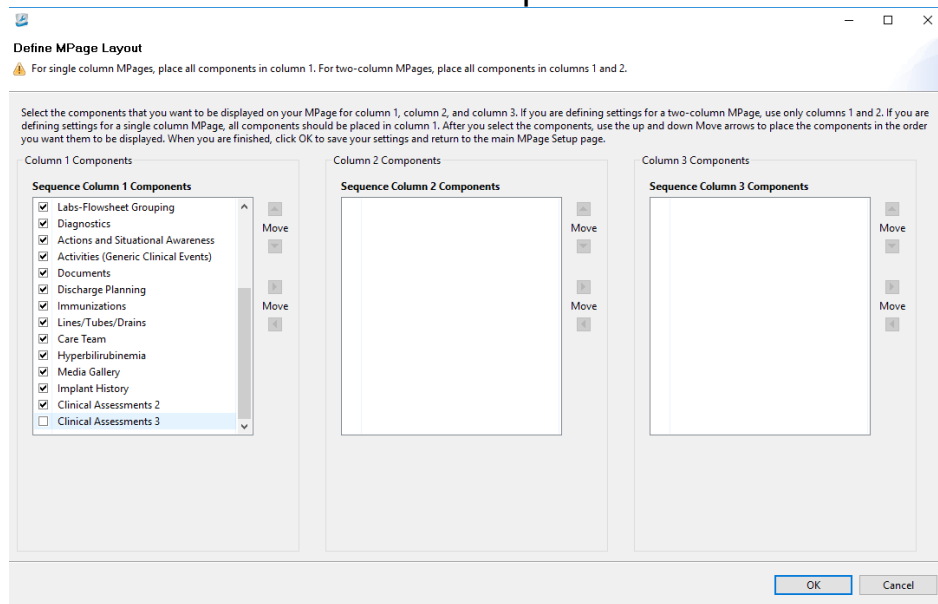
Using this Wizard

- [Defining filters for all components](#)
- [Filter types](#)
- [Learn more about MPages](#)
- [More about View Saved Settings](#)

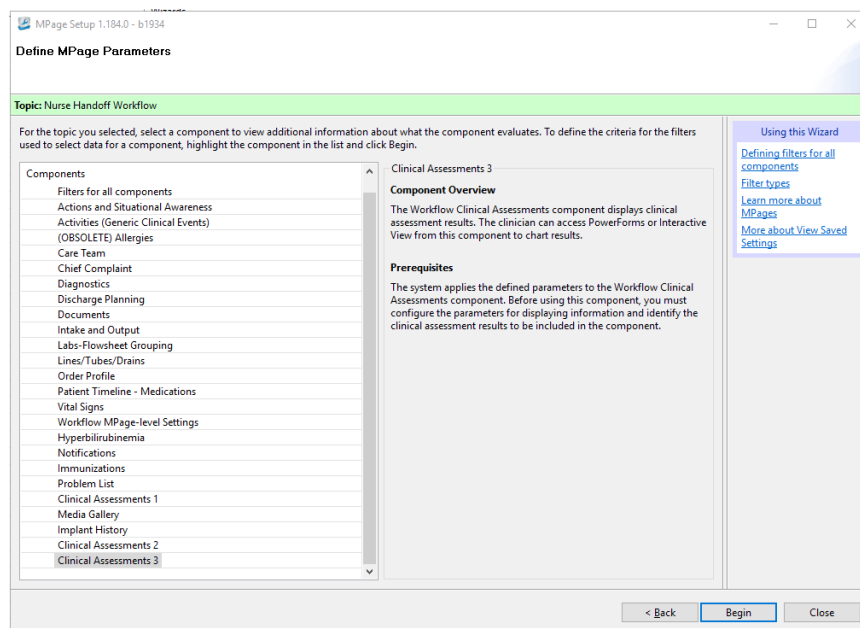
< Back Begin Close

Select the newly added clinical assessment component. Select OK. In this example Clinical

## Assessments 3 is the new component.

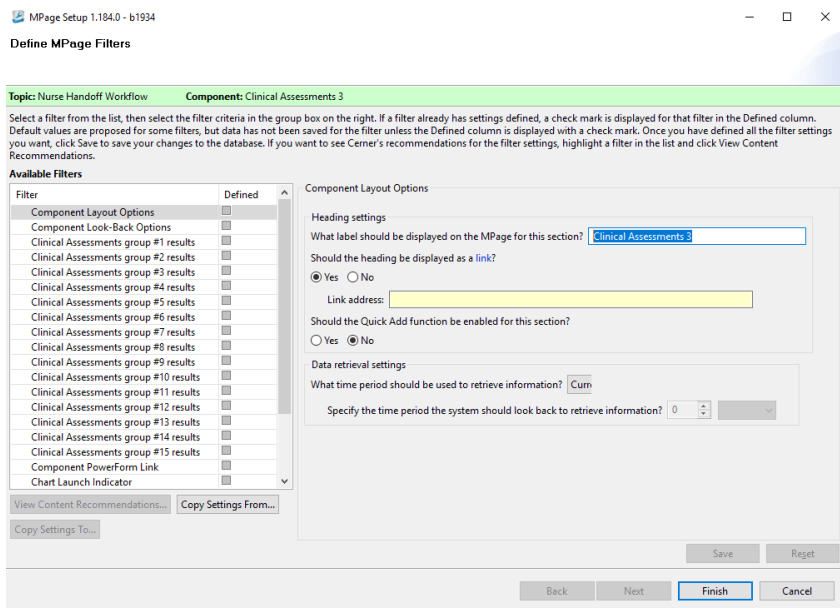


## Select newly added components Begin



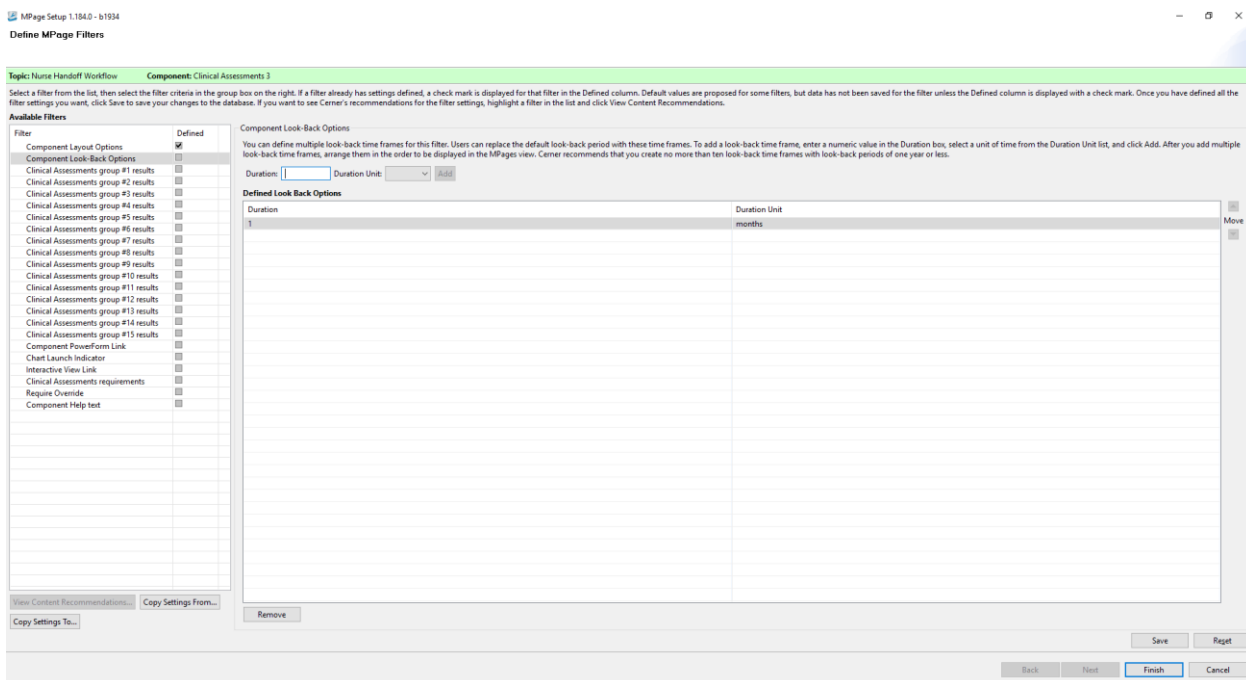
In Component Layout Options à Heading settings, name Component as per Organization standards. This is the name that will be displayed in PowerChart. Configure any additional settings. Select save.

- Under Data retrieval settings, select what time period should be used to retrieve information
  - Set to all encounters (if required by E2P)



Select Component Look-Back Options. Configure additional look back periods as required. Select save.

- This allows it to be selectable directly from the MPage. Recommended to default to a shorter duration to improve load times/system performance.



Select Clinical Assessment group #1 results Search for defined event code used for PHQ-9 and/or GAD-7 qualification. Select Save.

- If event codes are not in same event set it is best to utilize group 1 and group 2. If in same event set, both code values can be grouped together in Clinical Assessment group #1

MPage Setup 1.1842 - 81934

### Define MPage Filters

**Topic:** Nurse Handoff Workflow **Component:** Clinical Assessments 1

Select a filter from the list, then select the filter criteria in the group box on the right. If a filter already has settings defined, a check mark is displayed for that filter in the Defined column. Default values are proposed for some filters, but data has not been saved for the filter unless the Defined column is displayed with a check mark. Once you have defined all the filter settings you want, click Save to save your changes to the database. If you want to use Cerner's recommendations for the filter settings, highlight a filter in the list and click View Content Recommendations.

**Available Filters**

Filter	Defined
Component Layout Options	<input checked="" type="checkbox"/>
Component Look Back Options	<input checked="" type="checkbox"/>
Clinical Assessments group #1 results	<input type="checkbox"/>
Clinical Assessments group #2 results	<input type="checkbox"/>
Clinical Assessments group #3 results	<input type="checkbox"/>
Clinical Assessments group #4 results	<input type="checkbox"/>
Clinical Assessments group #5 results	<input type="checkbox"/>
Clinical Assessments group #6 results	<input type="checkbox"/>
Clinical Assessments group #7 results	<input type="checkbox"/>
Clinical Assessments group #8 results	<input type="checkbox"/>
Clinical Assessments group #9 results	<input type="checkbox"/>
Clinical Assessments group #10 results	<input type="checkbox"/>
Clinical Assessments group #11 results	<input type="checkbox"/>
Clinical Assessments group #12 results	<input type="checkbox"/>
Clinical Assessments group #13 results	<input type="checkbox"/>
Clinical Assessments group #14 results	<input type="checkbox"/>
Clinical Assessments group #15 results	<input type="checkbox"/>
Component PowerForm Link	<input type="checkbox"/>
Chart Launch Indicator	<input type="checkbox"/>
Interactive View Link	<input type="checkbox"/>
Clinical Assessments requirements	<input type="checkbox"/>
Require Override	<input type="checkbox"/>
Component Help text	<input type="checkbox"/>

**Starts with:**

Display	Description
Total Severity Score	Total Severity Score
Total Severity Score PHQ-9	Total Severity Score PHQ-9
Total Severity Score PHQ-9-OV	Total Severity Score PHQ-9-OV

**Contains:**

Display	Description
---------	-------------

**Event Set Hierarchy**

- ☐ Anxiety Information
- ☐ Gastrointestinal Assessment
- ☐ Head Sounds Assessment
- ☐ Hemodynamic Assessment
- ☐ Intracranial Calculations
- ☐ Musculoskeletal/Activity Assessment
- ☐ Chest Tubes
- ☐ Sternal Drain/Tubes
- ☐ Neurological Assessment
- ☐ Oxygenation Assessment
- ☐ Pediatric: Cerna Assessment
- ☐ Pupils Assessment
- ☐ Cranial Nerve Assessment
- ☐ Psychosocial Admission Information
- ☐ Suicide Risk Assessment
- ☐ Hemorrhage Risk Assessment
- ☐ Psychological Functions
- ☐ Initial Depression Screening
- ☒ Detailed Depression Screening
  - ☐ Unable to Tolerate or Heavy Sleep
  - ☐ Feeling Tired or Little Energy
  - ☐ Poor Appetite or Chewing
  - ☐ Feeling Bad About Yourself
  - ☐ Trouble Concentrating
  - ☐ Moving or Speaking Slowly
  - ☐ Thoughts Better Off Dead or Hurting Self
  - ☐ Detailed Depression Screen Score
  - ☐ Total Depression Screen Score
  - ☐ Total Severity Score
  - ☐ Total Symptom Score
  - ☐ Depression Screening Comment
  - ☐ Within One Year Postpartum
- ☐ Mental Health Treatment History
- ☐ Substance Abuse Assessment
- ☐ GAD-7 Assessment
- ☐ Pediatric Violence Screen
- ☐ CIMA-AD
- ☐ CIMA-IV

MPage Setup 1.1842 - 81934

### Define MPage Filters

**Topic:** Nurse Handoff Workflow **Component:** Clinical Assessments 1

Select a filter from the list, then select the filter criteria in the group box on the right. If a filter already has settings defined, a check mark is displayed for that filter in the Defined column. Default values are proposed for some filters, but data has not been saved for the filter unless the Defined column is displayed with a check mark. Once you have defined all the filter settings you want, click Save to save your changes to the database. If you want to use Cerner's recommendations for the filter settings, highlight a filter in the list and click View Content Recommendations.

**Available Filters**

Filter	Defined
Component Layout Options	<input checked="" type="checkbox"/>
Component Look Back Options	<input checked="" type="checkbox"/>
Clinical Assessments group #1 results	<input type="checkbox"/>
Clinical Assessments group #2 results	<input checked="" type="checkbox"/>
Clinical Assessments group #3 results	<input type="checkbox"/>
Clinical Assessments group #4 results	<input type="checkbox"/>
Clinical Assessments group #5 results	<input type="checkbox"/>
Clinical Assessments group #6 results	<input type="checkbox"/>
Clinical Assessments group #7 results	<input type="checkbox"/>
Clinical Assessments group #8 results	<input type="checkbox"/>
Clinical Assessments group #9 results	<input type="checkbox"/>
Clinical Assessments group #10 results	<input type="checkbox"/>
Clinical Assessments group #11 results	<input type="checkbox"/>
Clinical Assessments group #12 results	<input type="checkbox"/>
Clinical Assessments group #13 results	<input type="checkbox"/>
Clinical Assessments group #14 results	<input type="checkbox"/>
Clinical Assessments group #15 results	<input type="checkbox"/>
Component PowerForm Link	<input type="checkbox"/>
Chart Launch Indicator	<input type="checkbox"/>
Interactive View Link	<input type="checkbox"/>
Clinical Assessments requirements	<input type="checkbox"/>
Require Override	<input type="checkbox"/>
Component Help text	<input type="checkbox"/>

**Starts with:**

Display	Description
GAD-7	RR GAD-7
GAD-7 Anxiety - Form	GAD-7 Anxiety - Form
GAD-7 Score	GAD-7 Score
GAD-7 Sunny Score Grid	GAD-7 Sunny Score Grid
GAD-7 - Test	GAD-7 - Test
gabapentin dimethylglutamate	gabapentin dimethylglutamate
gabapentin	gabapentin
gabapentin dimethylglutamate	gabapentin dimethylglutamate
gabapentin	gabapentin
gabapentin dimethylglutamate	gabapentin dimethylglutamate
gabapentin	gabapentin

**Contains:**

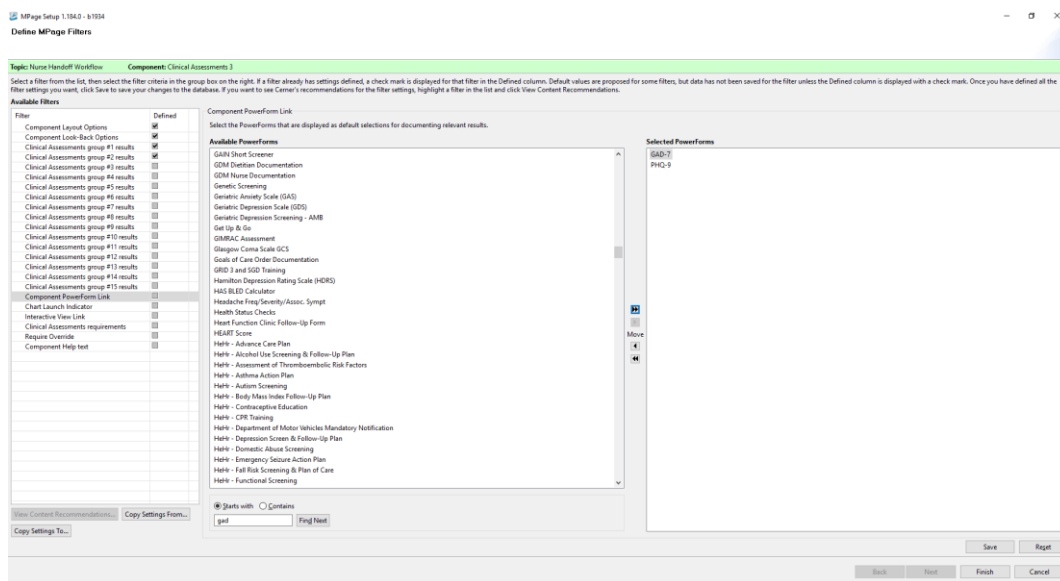
Display	Description
ANTI-GAD65	ANTI-GAD65
Cau - Magalys Pad	Cau - Magalys Pad
Cau - Magalys Pad Serial Number	Cau - Magalys Pad Serial Number
Child GAD-7 Score	Child GAD-7 Score
Father GAD-7 Score	Father GAD-7 Score
Generalized Anxiety Disorder 7 (GAD-7)	Generalized Anxiety Disorder 7 (GAD-7)
Mother GAD-7 Score	Mother GAD-7 Score
Other Family GAD-7 Score	Other Family GAD-7 Score

**Event Set Hierarchy**

- ☐ Fetal Neonatal Assessment Education
- ☐ Fetal Presentation
- ☐ Fetal Status
- ☐ Fever
- ☐ FHR Monitoring
- ☐ Flow Settings
- ☐ Fluid Volume Education
- ☐ Food/Nutrition Related History Outcomes
- ☐ Foreign Body Removal
- ☐ Formula Changes
- ☐ Free Play Site
- ☐ Gastrointestinal
- ☐ Gastrointestinal
- ☐ Gastrointestinal
- ☐ Gastrointestinal Assessment
- ☐ Gastrointestinal LTC
- ☐ Gastrointestinal Oncology
- ☐ Gastrointestinal Rehab CCC
- ☐ Gastrointestinal Tubes
- ☐ General Education
- ☐ General Neonatal Neonate Education
- ☒ Generalized Anxiety Disorder 7 (GAD-7)
  - ☐ Item Counts
  - ☐ Unable to Control Worry
  - ☐ Worrying Too Much
  - ☐ Trouble Relaxing
  - ☐ Restlessness
  - ☐ Irritable
  - ☐ Fear
  - ☐ Problem Severity
  - ☐ GAD-7 Score
- ☐ Genitalia Assessment
- ☐ Genitourinary
- ☐ Genitourinary
- ☐ Genitourinary LTC

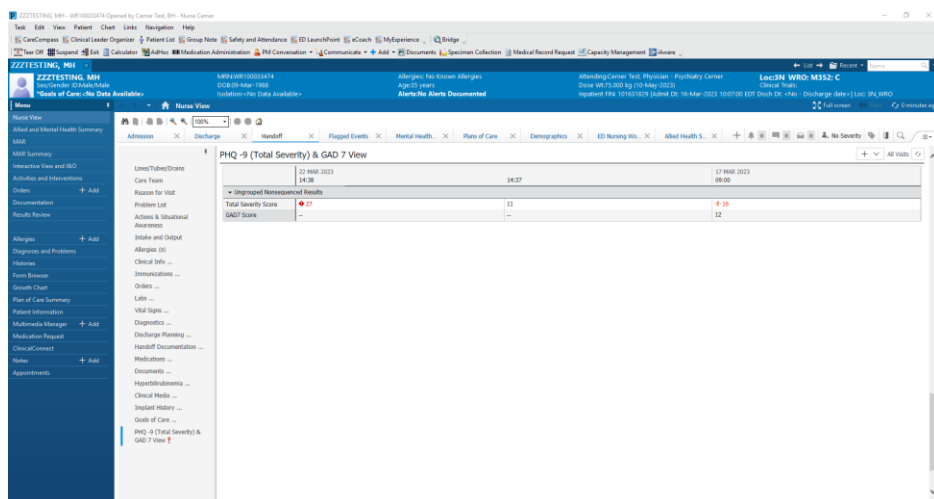
Select Component PowerForm Link and/or Interactive View Link. Configure quick charting for PowerForms and/or Interactive view if needed. Select Save à Finish

- Allows users to chart a PHQ-9 or GAD-7 directly from the dashboard



## Cycle Servers 535 and 72

View configuration on front end by navigating to the MPage this component has been added to.



## Patient and Provider Discharge Summary

Listed below are examples and build steps of how one Oracle hospital built the patient and provider discharge summary

Navigate to Oracle Wiki

<https://wiki.cerner.com/display/public/reference/Understand+Dynamic+Documentation+EMR+Content+-+Cerner+Basic+Content>

Identify pieces of EMR content that could be used to meet requirement.

*Scheduled Appointments and Follow ups example below*

# Scheduled Appointments (Physician-Facing)

Any appointments currently scheduled for the patient and accompanying information documented in the scheduling tables.

Scheduled Appointments			
Appointment Type	When	Where	Contact Information
Generic Check up Appt	04/19/2016 20:30 CDT	Baseline West Primary Care Clinic 1234 Main	+91-8885552222

## Technical Information

### Example Markup

```
<div class="ddemrcontent" dd:contenttype="FUTURE_APPTS" dd:referenceuuid="18AF1EC5-77AB-4303-B720-E0006FBFA22F"></div>
```

# Follow-Up Instructions (Physician-Facing)

A version of the patient's follow-up instructions that is displayed in the physician-facing reference templates. Information shown to the physician regarding necessary follow-up care is displayed in a table that includes columns for With, When, and Contact Information. Any additional instructions given by the physician are displayed beneath the columns. If information is not available, the text **No qualifying data available** is displayed instead.

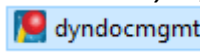
Follow Up Instructions		
With	When	Contact Information
Eric Siciliano	01/28/2016 11:30 CST	4115 Carondelet Drive Overland Park, KS 66223-
Additional Instructions: Take Visit Summary with you to the appointment.		
Follow up with primary care provider	Within 3 to 5 days	
Additional Instructions: No appointment scheduled.		
Austin Brown	Within 1 to 2 weeks, only if needed	64137 Seattle Grace Way Kansas City, MO 64108-
Additional Instructions:		

## Technical Information

### Example Markup

```
<div class="ddemrcontent" dd:contenttype="FOLLOW_UP" dd:referenceuuid="9DC024E8-603C-4A6A-83EA-8A96FE7EB9D2"></div>
```

*Note- If including scheduled appointments AND follow up instructions it is recommended to use the Physician Facing version of EMR content as it matches more closely together than the patient facing versions.*



Access dyndocmgmt tool . Load manifest. Navigate to EMR content.

Filters Formats EMR Content Reference Templates						
Add	Remove from List	Each EMR Content is given a unique non-editable Reference UUID when created and cannot be overwritten				
Name	Description	Type	Source	Filter	Format	Reference UUID
Allergies	Active Allergies	Allergies	cernerbasiccontent	Allergies/cernerbasiccontent	cernerbasiccontent/formats/en/allergy_en.usult	1445A201-FD91-4A02-B645-300DC940C4B8
Assessment and Plan	Assessment and Plan	Document Component	cernerbasiccontent	Assessment and Plan/cernerbasiccontent	cernerbasiccontent/formats/en/assess_en.usult	9E002D1-070B-4002-9E5B-6506B61DA9FE
Care Team	Care Team	Encounter Info	cernerbasiccontent	Encounter/cernerbasiccontent	cernerbasiccontent/formats/en/careteam_en.usult	DF35786-D939-4A4A-AB86-89595EACD163
Chief Complaint	Latest Chief Complaint	Patient Care Measurements	cernerbasiccontent	Chief Complaint/cernerbasiccontent	cernerbasiccontent/formats/en/patcaremeasureme_...	ECF53999-0D03-4DCC-B002-CC8E95C648BA
Chief Complaint and Reason For...	Chief Complaint and Reason For Visit	Chief Complaint / RFI	cernerbasiccontent	Chief Complaint and Reason For Visit/cernerbasicco...	cernerbasiccontent/formats/en/crft_en.usult	F220DCE-7667-4EFC-8087-151BD1E46A7D
Demographics Alias Location Re...	Demographics Alias Location Registration PCP	Encounter Info	cernerbasiccontent	Encounter/cernerbasiccontent	cernerbasiccontent/formats/en/demolnagracceth_...	165C11F8-787A-4A06-91F6-D00F40417FC
Demographics Language Race E...	Demographics Language Race Ethnicity	Encounter Info	cernerbasiccontent	Encounter/cernerbasiccontent	cernerbasiccontent/formats/en/demolnagracceth_...	5991C999-F0C9-4A35-94E3-B003478B1371
Demographics Name Contact G...	Demographics Name Contact Gender DOB	Encounter Info	cernerbasiccontent	Encounter/cernerbasiccontent	cernerbasiccontent/formats/en/demonamecontact_...	D5888080-37F0-49F8-86C8-B00319901A27
Demographics Patient Facing	Demographics Patient Facing	Encounter Info	cernerbasiccontent	Encounter/cernerbasiccontent	cernerbasiccontent/formats/en/demographicsptfaci...	51F22E71-920B-4A97-A270-F9A7FC90F8A
Demographics Patient Name Full	Demographics Patient Name Full	Encounter Info	cernerbasiccontent	Encounter/cernerbasiccontent	cernerbasiccontent/formats/en/demopnamefull.usult	48A18750-E486-48D4-8F32-4E8A4E214063
Devices and Equipment	Devices and Equipment	Patient Care Measurements	cernerbasiccontent	Devices and Equipment/cernerbasiccontent	cernerbasiccontent/formats/en/patcaremeasureme...	D2D36578-30E0-43BF-9D38-AB61AF838886
Diagnoses	Diagnoses List	Diagnoses	cernerbasiccontent	Diagnoses/cernerbasiccontent	cernerbasiccontent/formats/en/diagnoses_en.usult	12A77098-5460-46C7-98AE-D05387420634
Diagnoses Patient Facing	Diagnoses List Patient Facing	Diagnoses	cernerbasiccontent	Diagnoses/cernerbasiccontent	cernerbasiccontent/formats/en/diagnosespatient_e...	89A078EC-C346-401D-B311-5650D79D9F
DxCodes	Diagnosis Codes	Diagnoses and orders	cernerbasiccontent	DxOrders/cernerbasiccontent	cernerbasiccontent/formats/en/dxorder_en.usult	453F3AB9-9E4D-4109-8EAA-9C832375262
DxOrders	Active Diagnosis with Orders	Diagnoses and orders	cernerbasiccontent	DxOrders/cernerbasiccontent	cernerbasiccontent/formats/en/dxorder_en.usult	28A0F401-9012-45AF-8B0F-CD5503253E54
ED Assessment and Plan	ED Assessment and Plan	Document Component	cernerbasiccontent	ED Assessment and Plan/cernerbasiccontent	cernerbasiccontent/formats/en/edassessmentand_pla...	4C7F43D2-7863-4099-BAAB-746E8030BFD0
Family History	Family History	Family History	cernerbasiccontent	Family History/cernerbasiccontent	cernerbasiccontent/formats/en/familyhistory_en.usult	1F1618D1-D181-4E00-9B64-51F409E7626
Followup Patient Facing	Followup	Follow Up	cernerbasiccontent	Followup/cernerbasiccontent	cernerbasiccontent/formats/en/followupptfacing_e...	83F44866-6106-46A4-8DD0-5D4D4E82AC
Footnotes	Footnotes	Footnote	cernerbasiccontent	Footnotes/cernerbasiccontent	cernerbasiccontent/formats/en/footnote_en.usult	0381CB1F-8571-4A49-81D5-8CD008F34A28
Future Appointments Patient Fa...	Future Appointments Patient Facing	Future Appointments	cernerbasiccontent	Future Appointments/cernerbasiccontent	cernerbasiccontent/formats/en/futureapptptfacing...	877D911F-88C4-4F12-80FB-7C81AC8560A
Future Orders Patient Facing	Future Orders Patient Facing	Orders	cernerbasiccontent	Future Orders Patient Facing/cernerbasiccontent	cernerbasiccontent/formats/en/orders_en.usult	1C84793A-A375-4215-9F40-D48A0E000374
Goals	Goals	Goals	cernerbasiccontent	Goals/cernerbasiccontent	cernerbasiccontent/formats/en/goals_en.usult	A15AB92F-2E61-4023-AE82-B830D1938418
Health Concerns	Health Concerns	Health Concerns	cernerbasiccontent	Health Concerns/cernerbasiccontent	cernerbasiccontent/formats/en/healthconcerns_en...	1ABE14D5-5778-4A05-918F-13135C50A4FD
History of Present Illness	History of Present Illness	Document Component	cernerbasiccontent	History of Present Illness/cernerbasiccontent	cernerbasiccontent/formats/en/hpi_en.usult	50306066-B513-41B3-82B8-0F6E379CAB0
Home Treatments	Home Treatments	Patient Care Measurements	cernerbasiccontent	Home Treatments/cernerbasiccontent	cernerbasiccontent/formats/en/patcaremeasureme...	348244CD-47D5-49FD-978E-34EF46043F
Hospital Course	Hospital Course	Patient Care Measurements	cernerbasiccontent	Hospital Course/cernerbasiccontent	cernerbasiccontent/formats/en/hospitalcourse_en.usult	80347283-2161-40C7-9A3D-0C7FF7F5115E
Images	Images	Images	cernerbasiccontent	Images/cernerbasiccontent	cernerbasiccontent/formats/en/images_en.usult	2D4D1119-2873-40E0-95A8-13A07C93662E
Immunization This Visit	Immunization This Visit	Immunizations Categorized	cernerbasiccontent	Immunization This Visit/cernerbasiccontent	cernerbasiccontent/formats/en/immunizationsthisv...	4C8BADA0-6838-4047-87AE-A498C0916643
Immunizations	Immunizations	Immunizations Categorized	cernerbasiccontent	Immunizations/cernerbasiccontent	cernerbasiccontent/formats/en/immunizations_en...	40E6A0F9-3679-4F4B-A13D-5E13AF8FF86
Implanted Devices	Implanted Devices	Implanted Devices	cernerbasiccontent	Implanted Devices/cernerbasiccontent	cernerbasiccontent/formats/en/implanteddevices_e...	8FA34CF-9666-454F-8F63-FEDB34FG4A87
Implanted Devices Patient Facing	Implanted Devices Patient Facing	Implanted Devices	cernerbasiccontent	Implanted Devices Patient Facing/cernerbasiccontent	cernerbasiccontent/formats/en/implanteddevicespa...	D2CDB84E-EC8D-4199-98D0-490ACD5AF6CA
Labs V2 for Providers	Labs V2 for Providers	Labs Orders and Results	cernerbasiccontent	Labs V2/cernerbasiccontent	cernerbasiccontent/formats/en/labsv2provider_en.usult	F00A1659-AE55-4ACC-A86C-C3B2A321A4A1
Maternal Labs	Maternal Labs	Patient Care Measurements	cernerbasiccontent	Maternal Labs Filter/cernerbasiccontent	cernerbasiccontent/formats/en/maternallabs_en.usult	CCB251F1-9F8C-428F-A17D-90E0F9B4327
Medications	Ordered Medications	Medications	cernerbasiccontent	Medications/cernerbasiccontent	cernerbasiccontent/formats/en/medic_en.usult	38181344-329A-4C22-8E0A-40F08B037AC
Medications Administration	Medications Administration	Medication Administration	cernerbasiccontent	Medications Administration/cernerbasiccontent	cernerbasiccontent/formats/en/medadmin_en.usult	FEF918D9-FB43-4580-81CA-F3818A1E1CE9
Medications Reconciliation	Medications Reconciliation	Medications Reconciliation	cernerbasiccontent	Medications Reconciliation/cernerbasiccontent	cernerbasiccontent/formats/en/medrecon_en.usult	868E87D-FA90-41DC-A742-87E3A0AC0E89
Medications Reconciliation Sho...	Medications Reconciliation Show Next Data Column	Medications Reconciliation	cernerbasiccontent	Medications Reconciliation/cernerbasiccontent	cernerbasiccontent/formats/en/medrecon_nextdata...	83D32EC1-780B-410B-83FB-6A796A7ABEC7

Find equivalent EMR content in manifest.

**Note\***

- *UUID might be different than CernerWiki.*
- *If unable to find a piece EMR content found on CernerWiki, then it may not be in your files. Please follow organizational policy for bringing items from Cerner into your manifest. This may require building new filter and format files in the dyndocmgmt tool.*

Navigate to dynamic documentation files. Open with code editor (ie. Notepad, notepad++, etc..)

ID Consult Note	1
Immediate_Post_Op_Note	1
InternalMedProgressNote_en	1
Leave of Absence	1
Medical Student Note	1
Mental Health Inpatient Discharge Instructions	1
MHA Neuropsychological Note Template	1
MHA Psych Consult Note Template	1
MHA Psych IP Admission Note Template	1

```
Mental Health Inpatient Discharge Instructions - Notepad
File Edit Format View Help
<?xml version="1.0" encoding="windows-1252"?>
<?dynamic-document type="template" version="8.0"?>
<!DOCTYPE html PUBLIC "-//W3C//DTD XHTML 1.0 Strict//EN" "http://www.w3.org/TR/xhtml1/DTD/xhtml1-strict.dtd">
<html xmlns="http://www.w3.org/1999/xhtml" xmlns:dd="DynamicDocumentation">
  <head>
    <title/>
  </head>
  <body>
    <div style="font-family: tahoma,arial; font-size: 9pt;">
      <div class="ddsection ddremovable" style="padding: 4px;" dd:sectioncode="LOINC!46240-8">
        <div class="ddemrcontent" dd:contenttype="ENCNTRINFO" dd:referenceuid="51F22E71-926B-4A97-A270-F9AF7DC50F8A"/>
      </div>
      <hr style="height:4px;border-width:0;background-color:gray"/>
      <div class="ddsection ddremovable" dd:btnfloatingstyle="float-right" style="padding: 4px;">
        <h1 style="padding: 10px; background-color: #000; color: #FFFFFF;">
          <span class="ddsectiondisplay">Discharge Instructions</span>
        </h1>
        <table width="100%" style="border: 0; border-collapse: collapse;">
          <colgroup>
            <col valign="top" width="50%"/>
            <col valign="top" width="50%"/>
          </colgroup>
          <tr>
```

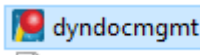
Identify where new section(s) need to be positioned and build in HTML. Example below of scheduled hospital appointments and follow up sections.



```

<span class="ddsectiondisplay">What to do next</span>
</h1>
<div class="ddsubsection ddrefreshable ddinsertfreetext ddremovable" style="border-bottom: 1px solid #999; margin-top: 10px;" dd:sectioncode="LOINC!18776-5">
  <span class="ddsectiondisplay">
    <span style="font-weight: bold; font-size: 15pt;">Scheduled Hospital Appointments</span>
    <br/>
  </span>
  <div class="ddemrcontent" style="margin-top: 10px;" dd:contenttype="FUTURE_APPTS" dd:referenceuid="BD8A9803-517A-4C6B-B45E-C76EADC4285"/>
</div>
<div class="ddsubsection ddrefreshable ddinsertfreetext ddremovable" style="border-bottom: 1px solid #999; margin-top: 10px;" dd:sectioncode="LOINC!69730-0">
  <span class="ddsectiondisplay">
    <span style="font-weight: bold; font-size: 15pt;">Follow Ups</span>
    <br/>
  </span>
  <div class="ddemrcontent" style="margin-top: 10px;" dd:contenttype="FOLLOW_UP" dd:referenceuid="6EFDfE3E-6074-49A7-AB97-05CAA4954EF1"/>
</div>

```



Save File. Open and select Import

Task View Help

Manifest File: [file path] Scan for Content

Filters: Formats EMR Content Reference Templates:

Add	Remove from List	Each EMR Content is given a unique non-editable Reference UUID when created and cannot be overwritten				
Name	Description	Type	Source	Filter	Format	Reference UUID
Test Results	Completed Laboratory Tests	Tests Pending	cernerbasiccontent	Test Results/cernerbasiccontent	/cernerbasiccontent/formats/en/testresults_en.uslt	9069485-58E3-4947-806D-C0E3C6A7AC
Tests Performed	Completed and Pending Laboratory and Radiology Tests	Tests Pending	cernerbasiccontent	Tests Performed/cernerbasiccontent	/cernerbasiccontent/formats/en/testperformed_en.uslt	506950F-E66F-482B-A46E-6DCD1275FE9
Tag - Tagged Text	Tagged Text	Tag Text	cernerbasiccontent	Tag - Tagged Text/cernerbasiccontent	/cernerbasiccontent/formats/en/taggedtext_en.uslt	5D7E2B31-5802-4D24-9539-DA023A5F368
Social History	Social History	Social History	cernerbasiccontent	Social History/cernerbasiccontent	/cernerbasiccontent/formats/en/socialhistory_en.uslt	9ACD8023-2144-40FE-9C08-4FA2B23CF5F
Radiology for Providers	Radiology Orders and Results for Providers	Radiology Orders and Results	cernerbasiccontent	Radiology/cernerbasiccontent	/cernerbasiccontent/formats/en/radiologyprovider_en.uslt	2ETC5216-ABCA-4865-B9C5-C5C1A0AC6090
Procedures	Procedures	Procedure History	cernerbasiccontent	Procedures/cernerbasiccontent	/cernerbasiccontent/formats/en/procedures_en.uslt	A74F4B45-973D-4302-937C-9215A07B0B3D
Problems	Active Problems	Problems	cernerbasiccontent	Problems/cernerbasiccontent	/cernerbasiccontent/formats/en/problem_en.uslt	43D47F75-871A-4309-8A41-15612C1A3463
Problems Patient Facing	Problems Patient Facing	Problems	cernerbasiccontent	Problems/cernerbasiccontent	/cernerbasiccontent/formats/en/problemspatient_en.uslt	58AF105-C023-4209-854B-790A7676AC
Patient Education	Patient Education	Patient Education	cernerbasiccontent	Patient Education/cernerbasiccontent	/cernerbasiccontent/formats/en/pated_en.uslt	F3707019-8923-4277-873D-978AA49A8A7B
Chief Complaint	Latest Chief Complaint	Patient Care Measurements	cernerbasiccontent	Chief Complaint/cernerbasiccontent	/cernerbasiccontent/formats/en/patcaremeasureme..._en.uslt	ECF33099-D2D1-4DCC-8002-CFEED9CA68BA
Devices and Equipment	Devices and Equipment	Patient Care Measurements	cernerbasiccontent	Devices and Equipment/cernerbasiccontent	/cernerbasiccontent/formats/en/patcaremeasureme..._en.uslt	D2D36578-306D-438F-4058-AB81AF938886
Home Treatments	Home Treatments	Patient Care Measurements	cernerbasiccontent	Home Treatments/cernerbasiccontent	/cernerbasiccontent/formats/en/patcaremeasureme..._en.uslt	3482ACD9-47D3-498D-778E-34F6A6663F
Hospital Course	Hospital Course	Patient Care Measurements	cernerbasiccontent	Hospital Course/cernerbasiccontent	/cernerbasiccontent/formats/en/hospitalcourse_en.uslt	8C347283-2161-40C7-9A3D-0C7F771511E
Material Labs	Material Labs	Patient Care Measurements	cernerbasiccontent	Material Labs Filter/cernerbasiccontent	/cernerbasiccontent/formats/en/materiallabs_en.uslt	CC82D31F-9F8C-428F-A7D0-90E1DF8B4327
Patient Instructions	Patient Instructions	Patient Care Measurements	cernerbasiccontent	Patient Instructions/cernerbasiccontent	/cernerbasiccontent/formats/en/patientinstructions..._en.uslt	A85D0A1F-9681-4B4C-AFD2-6ADBC723A82
Professional Skill Services	Professional Skill Services	Patient Care Measurements	cernerbasiccontent	Professional Skill Services/cernerbasiccontent	/cernerbasiccontent/formats/en/patcaremeasureme..._en.uslt	845CE3CA-A451-415E-90F5-0E2601C607FE
Special Services Community Res...	Special Services and Community Resources	Patient Care Measurements	cernerbasiccontent	Special Services and Community Resources/cerna..._en.uslt	/cernerbasiccontent/formats/en/patcaremeasureme..._en.uslt	5D93E446-2046-4F6D-91D0-5D5B055605C
Vital Signs and Measurements C...	Latest Vital Signs and Measurements	Patient Care Measurements	cernerbasiccontent	Vital Signs and Measurements ED/cernerbasiccont..._en.uslt	/cernerbasiccontent/formats/en/vitalmeasurements..._en.uslt	944031A-7801-42D5-5271-F05C76B78784
Vital Signs and Measurements C...	Vital Signs and Measurements Cardiology	Patient Care Measurements	cernerbasiccontent	Vital Signs and Measurements Cardiology/cernerba..._en.uslt	/cernerbasiccontent/formats/en/vitalmeasurements..._en.uslt	1034065-72D4-45C4-983A-1408D7D1D8B
Vital Signs and Measurements N...	Vital Signs and Measurements Neurology	Patient Care Measurements	cernerbasiccontent	Vital Signs and Measurements Neurology/cernerba..._en.uslt	/cernerbasiccontent/formats/en/vitalmeasurements..._en.uslt	7A04A1C3-29DC-4386-8814-8C84DF0595C2
Vital Signs and Measurements U...	Latest Vital Signs and Measurements Patient Facing	Patient Care Measurements	cernerbasiccontent	Vital Signs and Measurements Patient Facing/cernerba..._en.uslt	/cernerbasiccontent/formats/en/vitalmeasurements..._en.uslt	28734561-6308-4D1C-9424-17CB5607CEC
Vital Signs and Measurements U...	Vital Signs and Measurements Urology	Patient Care Measurements	cernerbasiccontent	Vital Signs and Measurements Urology/cernerba..._en.uslt	/cernerbasiccontent/formats/en/vitalmeasurements..._en.uslt	CTD086A8-CF05-48A4-850B-724B904CE6A9
Vital Signs and Measurements I...	Vital Signs and Measurements within 24 hours	Patient Care Measurements	cernerbasiccontent	Vital Signs and Measurements/cernerbasiccontent..._en.uslt	/cernerbasiccontent/formats/en/vitalmeasurements..._en.uslt	80787CA-7318-455B-8C34-F1C560A1777
Future Orders Patient Facing	Future Orders Patient Facing	Orders	cernerbasiccontent	Future Orders Patient Facing/cernerbasiccontent..._en.uslt	/cernerbasiccontent/formats/en/orders_en.uslt	1C34783A-4373-4218-9F4D-04B4200074
Referral Orders	Referral Orders	Orders	cernerbasiccontent	Referral Orders/cernerbasiccontent	/cernerbasiccontent/formats/en/referralorders_en.uslt	103FCA3A-0177-42FF-A069-39FC07AD3D0E
Medications Reconciliation	Medications Reconciliation	Medications Reconciliation	cernerbasiccontent	Medications Reconciliation/cernerbasiccontent	/cernerbasiccontent/formats/en/medrec_en.uslt	B06EEB7D-F48D-410C-4742-9E3AD0CEB9
Medications Reconciliation Sho...	Medications Reconciliation Show Next Dose Column	Medications Reconciliation	cernerbasiccontent	Medications Reconciliation/cernerbasiccontent	/cernerbasiccontent/formats/en/medrec_nextdose..._en.uslt	6D32EEC1-7808-418F-8338-64796A7ABEC
Medications Reconciliation Sim...	Medications Reconciliation Simplified	Medications Reconciliation	cernerbasiccontent	Medications Reconciliation Simplified/cernerbasico..._en.uslt	/cernerbasiccontent/formats/en/medrecsimplified..._en.uslt	6B04BC5E-F3D4-4858-A098-4478B781EEA
Medications	Ordered Medications	Medications	cernerbasiccontent	Medications/cernerbasiccontent	/cernerbasiccontent/formats/en/meds_en.uslt	30181044-326A-4C22-8E0A-40F1D8B37AC
Medications with Categorized D...	Ordered Medications with Categorized Display	Medications	cernerbasiccontent	Medications/cernerbasiccontent	/cernerbasiccontent/formats/en/meds_en.uslt	38A4D525-7E32-4081-8099-969A4604848
Meds with Categorized Display ...	Meds with Categorized Display - No Home Meds	Medications	cernerbasiccontent	Medications/cernerbasiccontent	/cernerbasiccontent/formats/en/medscategorized..._en.uslt	7754D8F3-D619-4DED-43E3-C7707378AC
Medications Administration	Medications Administration	Medication Administration	cernerbasiccontent	Medications Administration/cernerbasiccontent	/cernerbasiccontent/formats/en/medsadmin_en.uslt	FEF918D9-F843-438D-81CA-F3818A1E1CE9
Lab v2 for Providers	Lab v2 for Providers	Lab Orders and Results	cernerbasiccontent	Lab v2/cernerbasiccontent	/cernerbasiccontent/formats/en/labv2provider_en.uslt	F00A165D-AE35-4C42-A08C-C8262A1A4A1
Tag - Tagged Labs	Tagged Labs	Labs	cernerbasiccontent	Lab/cernerbasiccontent	/cernerbasiccontent/formats/en/taggedlab_en.uslt	2AA3D748-E48A-4D4B-AD39-7E4BC083B89
Implanted Devices	Implanted Devices	Implanted Devices	cernerbasiccontent	Implanted Devices/cernerbasiccontent	/cernerbasiccontent/formats/en/implanteddevices_e..._en.uslt	8A9AC2F-9696-4546-9A93-F018A904897
Implanted Devices Patient Facing	Implanted Devices Patient Facing	Implanted Devices	cernerbasiccontent	Implanted Devices/cernerbasiccontent	/cernerbasiccontent/formats/en/implanteddevicecp..._en.uslt	D2C2D38A-EC0D-4799-982D-400AC3FAFCA
Immunization This Visit	Immunization This Visit	Immunizations, Categorized	cernerbasiccontent	Immunizations This Visit/cernerbasiccontent	/cernerbasiccontent/formats/en/immunizationthisvisi..._en.uslt	4C78A70A-6810-4D47-874F-4489C7D516A1

Save Manifest Import Done

For the provider discharge summary, the same organization made the following enhancements:

- Added in free text section titled "Follow up for Receiving Provider"
- Added in EMR content for DI Tests done on that encounter
- Added a spot to place tagged images

Navigate to Cerner Wiki

<https://wiki.cerner.com/display/public/reference/Understand+Dynamic+Documentation+EMR+Content+-+Cerner+Basic+Content>

Identify pieces of EMR content that could be used to meet requirement.

Diagnostic imaging example below

Radiology Results (Physician-Facing)

A physician-facing list of results for radiology exams performed on the patient during the current encounter. The interpretation is displayed along with the test name. If there are linked radiology orders, the interpretation is displayed once.

Note

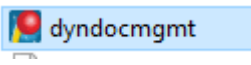
To obtain radiology results, you must verify that your radiology documentation is present in the Radiology Event Set grouper in the Event Set hierarchy.

**Radiology Results**  
MRI Abdomen w/ + w/o Contrast - 12/13/2015 19:58 CST, MRI Abdomen w/ Contrast - 12/13/2015 19:58 CST  
\_JH Interp  
MRI Ankle w/ Contrast Left - 12/13/2015 19:50 CST, MRI Ankle w/ Contrast Right - 12/13/2015 19:57 CST  
\_OS and OS  
MRI Brain w/o Contrast - 12/13/2015 17:44 CST  
asfadsfadsf  
MRI Pelvis w/o Contrast - 01/19/2016 18:00 CST  
\_one

Technical Information

Example Markup

<div class="ddemrcontent" dd.contentType="RADIOLOGY" dd.linkedrefresh="TESTS" dd.referenceuuid="607EB264-E5AA-4E18-9EBB-436AF1DAF0EF"></div>

Access dyndocmgmt tool  . Load manifest. Navigate to EMR content.













Filters: EMRs EMR Content Reference Templates							
Add		Remove from List		Each EMR Content is given a unique non-editable Reference UUID when created and cannot be overwritten			
Name	Description	Type	Source	Filter	Format	Reference UUID	
Assessment and Plan	Assessment and Plan	Document Component	Assessment and Plan	Assessment and Plan	Assessment and Plan	80220701-0001-4402-9045-30020400C48	
Care Team	Care Team	Encounter Info	Care Team	Care Team	Care Team	80220701-0001-4402-9045-30020400C48	
Chief Complaint	Chief Complaint	Patient Care Measurements	Chief Complaint	Chief Complaint	Chief Complaint	80220701-0001-4402-9045-30020400C48	
Chief Complaint and Reason For Visit	Chief Complaint and Reason For Visit	Chief Complaint and Reason For Visit	Chief Complaint and Reason For Visit	Chief Complaint and Reason For Visit	Chief Complaint and Reason For Visit	80220701-0001-4402-9045-30020400C48	
Demographics Alias Location Re.	Demographics Alias Location Registration PCP	Encounter Info	Demographics Alias Location Registration PCP	Demographics Alias Location Registration PCP	Demographics Alias Location Registration PCP	80220701-0001-4402-9045-30020400C48	
Demographics Language Race I.	Demographics Language Race Ethnicity	Encounter Info	Demographics Language Race Ethnicity	Demographics Language Race Ethnicity	Demographics Language Race Ethnicity	80220701-0001-4402-9045-30020400C48	
Demographics Name Contact G.	Demographics Name Contact Gender DOB	Encounter Info	Demographics Name Contact Gender DOB	Demographics Name Contact Gender DOB	Demographics Name Contact Gender DOB	80220701-0001-4402-9045-30020400C48	
Demographics Patient Facing	Demographics Patient Facing	Encounter Info	Demographics Patient Facing	Demographics Patient Facing	Demographics Patient Facing	80220701-0001-4402-9045-30020400C48	
Demographics Patient Name Full	Demographics Patient Name Full	Encounter Info	Demographics Patient Name Full	Demographics Patient Name Full	Demographics Patient Name Full	80220701-0001-4402-9045-30020400C48	
Devices and Equipment	Devices and Equipment	Patient Care Measurements	Devices and Equipment	Devices and Equipment	Devices and Equipment	80220701-0001-4402-9045-30020400C48	
Diagnoses	Diagnoses List	Diagnoses	Diagnoses	Diagnoses	Diagnoses	80220701-0001-4402-9045-30020400C48	
Diagnoses Patient Facing	Diagnoses List Patient Facing	Diagnoses	Diagnoses Patient Facing	Diagnoses Patient Facing	Diagnoses Patient Facing	80220701-0001-4402-9045-30020400C48	
DiCodes	Diagnoses Codes	Diagnoses and orders	Diagnoses Codes	Diagnoses Codes	Diagnoses Codes	80220701-0001-4402-9045-30020400C48	
DiOrders	Active Diagnosis with Orders	Diagnoses and orders	Diagnoses and orders	Diagnoses and orders	Diagnoses and orders	80220701-0001-4402-9045-30020400C48	
ID Assessment and Plan	ID Assessment and Plan	Document Component	ID Assessment and Plan	ID Assessment and Plan	ID Assessment and Plan	80220701-0001-4402-9045-30020400C48	
Family History	Family History	Family History	Family History	Family History	Family History	80220701-0001-4402-9045-30020400C48	
Followup Patient Facing	Followup	Followup	Followup	Followup	Followup	80220701-0001-4402-9045-30020400C48	
Footnotes	Footnotes	Footnotes	Footnotes	Footnotes	Footnotes	80220701-0001-4402-9045-30020400C48	
Future Appointments Patient Fa.	Future Appointments Patient Facing	Future Appointments	Future Appointments Patient Facing	Future Appointments Patient Facing	Future Appointments Patient Facing	80220701-0001-4402-9045-30020400C48	
Future Orders Patient Facing	Future Orders Patient Facing	Orders	Future Orders Patient Facing	Future Orders Patient Facing	Future Orders Patient Facing	80220701-0001-4402-9045-30020400C48	
Goals	Goals	Goals	Goals	Goals	Goals	80220701-0001-4402-9045-30020400C48	
Health Concerns	Health Concerns	Health Concerns	Health Concerns	Health Concerns	Health Concerns	80220701-0001-4402-9045-30020400C48	
History of Present Illness	History of Present Illness	Document Component	History of Present Illness	History of Present Illness	History of Present Illness	80220701-0001-4402-9045-30020400C48	
Home Treatments	Home Treatments	Patient Care Measurements	Home Treatments	Home Treatments	Home Treatments	80220701-0001-4402-9045-30020400C48	
Hospital Course	Hospital Course	Patient Care Measurements	Hospital Course	Hospital Course	Hospital Course	80220701-0001-4402-9045-30020400C48	
Images	Images	Images	Images	Images	Images	80220701-0001-4402-9045-30020400C48	
Immunization This Visit	Immunization This Visit	Immunizations Categorized	Immunization This Visit	Immunization This Visit	Immunization This Visit	80220701-0001-4402-9045-30020400C48	
Immunizations	Immunizations	Immunizations Categorized	Immunizations	Immunizations	Immunizations	80220701-0001-4402-9045-30020400C48	
Implanted Devices	Implanted Devices	Implanted Devices	Implanted Devices	Implanted Devices	Implanted Devices	80220701-0001-4402-9045-30020400C48	
Implanted Devices Patient Facing	Implanted Devices Patient Facing	Implanted Devices	Implanted Devices Patient Facing	Implanted Devices Patient Facing	Implanted Devices Patient Facing	80220701-0001-4402-9045-30020400C48	
Labs 12 For Providers	Labs 12 For Providers	Labs 12 For Providers	Labs 12 For Providers	Labs 12 For Providers	Labs 12 For Providers	80220701-0001-4402-9045-30020400C48	
Maternal Labs	Maternal Labs	Maternal Labs	Maternal Labs	Maternal Labs	Maternal Labs	80220701-0001-4402-9045-30020400C48	
Medications	Medications	Medications	Medications	Medications	Medications	80220701-0001-4402-9045-30020400C48	
Medications Administration	Medications Administration	Medications Administration	Medications Administration	Medications Administration	Medications Administration	80220701-0001-4402-9045-30020400C48	
Medications Reconciliation	Medications Reconciliation	Medications Reconciliation	Medications Reconciliation	Medications Reconciliation	Medications Reconciliation	80220701-0001-4402-9045-30020400C48	
Medications Reconciliation Sto.	Medications Reconciliation Sto.	Medications Reconciliation	Medications Reconciliation Sto.	Medications Reconciliation Sto.	Medications Reconciliation Sto.	80220701-0001-4402-9045-30020400C48	

Find equivalent EMR content in manifest.

Note\*

- *UUID might be different than CernerWiki.*
- *If unable to find a piece EMR content found on CernerWiki, then it may not be in your files. Please follow organizational policy for bringing items from Cerner into your manifest. This may require building new filter and format files in the dyndocmgmt tool.*

Navigate to dynamic documentation files. Open with code editor (ie. Notepad, notepad++, etc..)

Name	Date modified	Type	Size
 PedsAdmissionNP_en	09-Feb-2021 13:47	HTML Document	8 KB
 PedsConsultNote_en	09-Feb-2021 13:47	HTML Document	8 KB
 PedsDischargeNote_en	29-May-2020 09:49	HTML Document	7 KB
 PedsProgressNote_en	09-Feb-2021 13:48	HTML Document	4 KB
 Psychiatrist Admission Note Template	02-Mar-2021 14:12	HTML Document	14 KB
 Psychiatrist C&A Progress Note	02-Mar-2021 14:12	HTML Document	7 KB
 Psychiatrist Discharge Note Template	02-Mar-2021 15:00	HTML Document	6 KB
 Psychiatrist Progress Note Template	02-Mar-2021 14:13	HTML Document	9 KB
 Psychiatry Note Template	02-Mar-2021 14:14	HTML Document	7 KB
 Psychological Testing Note	13-Oct-2014 10:39	HTML Document	8 KB
 Psychological Testing Ongoing Progress ...	19-Oct-2014 16:40	HTML Document	3 KB
 Psychology Report	02-Mar-2021 14:14	HTML Document	9 KB

```

Psychiatrist Discharge Note Template - Notepad
File Edit Format View Help
<?xml version="1.0" encoding="UTF-8"?>
<?dynamic-document type="template" version="1.0"?>
<!DOCTYPE html SYSTEM "http://www.w3.org/TR/xhtml1/DTD/xhtml1-transitional.dtd">
<html xmlns="http://www.w3.org/1999/xhtml" xmlns:dd="DynamicDocumentation">
<head><title></title></head>
<body>
<div style="font-family:tahoma,arial; font-size:12px;">
<table width="100%">
<colgroup>
<col valign="top" width="66%"></col>
<col valign="top" width="34%"></col>

```

Identify where new section(s) need to be positioned and build in HTML. Example below

```

</div>

<div class="ddsection ddrefreshable ddinsertfreetext ddremovable" style="padding:4px;" dd:sectioncode="LOINC!10164-2">
<span class="ddsectiondisplay"><span style="font-weight:bold;text-decoration:underline;">Diagnostics</span></span>
<div class="ddemrcontent" dd:contenttype="RADIOLOGY" dd:linkedrefresh="TESTS" dd:referenceuuid="3E7C5216-A8CA-4B65-B9C5-C5C1A9AC6090"
</div>

```

If non EMR content is required, such as the Follow up for Receiving Provider, see below for HTML code.

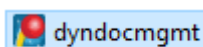
```

</div>

<div class="ddsection ddrefreshable ddinsertfreetext ddremovable" style="padding:4px;">
<span class="ddsectiondisplay"><span style="font-weight:bold;text-decoration:underline;">Follow Up For Receiving Provider</span></span>
<div class="ddfreetext ddremovable" dd:btnfloatingstyle="top-right"></div>
</div>

```

Save File. Open



and select Import

File	View	Help
Handful File		
Open	New	Scan for Content
Files	Formats	EMR Content
Reference Templates		
Add	Remove from List	Each EMR Content is given a unique non-editable Reference UUID when created and cannot be overwritten
Name	Description	Type
Test Results	Completed Laboratory Tests	Tests Pending
Tests Performed	Completed and Pending Laboratory and Radiology Tests	Tests Pending
Tag - Tagged Test	Tagged Test	Tag - Tagged Test
Social History	Social History	Social History
Radiology for Providers	Radiology Orders and Results for Providers	Radiology Orders and Results
Procedures	Procedures	Procedures
Problems	Active Problems	Problems
Problems Patient Facing	Problems Patient Facing	Problems
Patient Education	Patient Education	Patient Education
Chief Complaint	Latest Chief Complaint	Chief Complaint
Devices and Equipment	Devices and Equipment	Devices and Equipment
Home Treatments	Home Treatments	Home Treatments
Hospital Course	Hospital Course	Hospital Course
Maternal Labs	Maternal Labs	Maternal Labs
Patient Instructions	Patient Instructions	Patient Instructions
Professional Skill Services	Professional Skill Services	Professional Skill Services
Special Services Community Res.	Special Services and Community Resources	Special Services and Community Resources
Vital Signs and Measurements	Vital Signs and Measurements	Vital Signs and Measurements
Vital Signs and Measurements C	Vital Signs and Measurements Cardiology	Vital Signs and Measurements Cardiology
Vital Signs and Measurements N	Vital Signs and Measurements Neurology	Vital Signs and Measurements Neurology
Vital Signs and Measurements P	Vital Signs and Measurements Patient Facing	Vital Signs and Measurements Patient Facing
Vital Signs and Measurements U	Vital Signs and Measurements Urology	Vital Signs and Measurements Urology
Vital Signs and Measurements L	Vital Signs and Measurements within 24 hours	Vital Signs and Measurements within 24 hours
Future Orders Patient Facing	Future Orders Patient Facing	Future Orders Patient Facing
Referral Orders	Referral Orders	Referral Orders
Medications Reconciliation	Medications Reconciliation	Medications Reconciliation
Medications Reconciliation Sim	Medications Reconciliation Show Next Dose Column	Medications Reconciliation
Medications	Medications Reconciliation Simplified	Medications
Medications with Categorized D	Medications with Categorized Display	Medications
Medications with Categorized Display	Medications with Categorized Display - No Home Meds	Medications
Medications Administration	Medications Administration	Medications Administration
Labs v2 for Providers	Labs v2 for Providers	Labs v2 for Providers
Tag - Tagged Labs	Tagged Labs	Tag - Tagged Labs
Implanted Devices	Implanted Devices	Implanted Devices
Implanted Devices Patient Facing	Implanted Devices Patient Facing	Implanted Devices
Communication This Site	Communication This Site	Communication This Site
Save Results	Import	Close

# Major Depression Indicators – Inpatient

## Overall approach

The below includes a compilation of process indicators that can be measured for people with a main diagnosis of **major depression**. These indicators focus on the **inpatient setting** and were created based on the [Major Depression Quality Standard](#). These indicators are relevant to the main quality statements implemented, or E2P Ontario pilot sites have deemed that the indicator is measurable within Health Information Systems and valuable to collect for quality improvement opportunities. Reasons for not including indicators include them being patient self-reported, beyond the time frame of this project, not documented in HIS’ and more.

## Major depression denominator inclusion criteria:

- For diagnosis type, use Q2A with DSM-V to reflect the principal diagnosis.
- Age ≥ 18 years
- Within the hospital visit: between registration and discharge
- Your indicator denominator/patient cohort can be pulled from the data captured in the RAI

Diagnosis	DSM-V ICD-10-CM
Major depressive disorder, Recurrent episode	
Major depressive disorder, Recurrent episode, In full remission	F33.42
Major depressive disorder, Recurrent episode, In partial remission	F33.41
Major depressive disorder, Recurrent episode, Mild	F33.0
Major depressive disorder, Recurrent episode, Moderate	F33.1
Major depressive disorder, Recurrent episode, Severe	F33.2
Major depressive disorder, Recurrent episode, Unspecified	F33.9



Major depressive disorder, Recurrent episode, With psychotic features	F33.3
<b>Major depressive disorder, Single episode</b>	
Major depressive disorder, Single episode, In full remission	F32.5
Major depressive disorder, Single episode, In partial remission	F32.4
Major depressive disorder, Single episode, Mild	F32.0
Major depressive disorder, Single episode, Moderate	F32.1
Major depressive disorder, Single episode, Severe	F32.2
Major depressive disorder, Single episode, Unspecified	F32.9
Major depressive disorder, Single episode, With psychotic features	F32.3
Persistent depressive disorder (dysthymia)	F34 ( <i>see note*</i> )

\*Note: Dysthymia is coded as ICD-10 CM F34.1, however, all of F34 may be used for a broader definition of depression.

Comprehensive assessment	E2P Process Indicator	Percentage of people with major depression who receive a minimum of one PHQ-9s during their hospital visit
	Numerator and Denominator	<p>Numerator: # of patients with major depression who have 1 PHQ9 completed within the visit</p> <p>Denominator: # of patients with a main diagnosis of major depression</p> <p>See “Major depression denominator inclusion criteria” for details.</p> <p><b>E2P Update:</b> Beginning December 2024, E2P sites have elected to include a minimum of ‘one’ PHQ-9 during the hospital visit (previously 2 included). This update reflects the preference by clinical teams to utilize the PHQ-9 for screening (all patients) and establish a baseline in relation to shorter inpatient length of stay and likelihood of community-based care following admission.</p>
	Definitions	<p>The PHQ-9 is a validated tool for assessing the severity of symptoms and degree of functional impairment. It is one component of a comprehensive assessment.<sup>1</sup> Frequent measurement of symptoms using the PHQ-9 allows providers to know when the patient is having a full response, partial response, or no response to treatment. This information helps in making decisions about how to adjust treatment. There are no strict guidelines on how often the PHQ-9 should be re-administered in an inpatient setting.<sup>2</sup> The Evidence2Practice Ontario program suggests that the PHQ-9 be completed at least once during the person’s hospital stay.</p>

	<b>E2P Process Indicator</b>	<b>Percentage of people with major depression who receive a minimum of one GAD-7 during their hospital visit</b>
	Numerator and Denominator	<p>Numerator: # of patients with major depression who have 1 GAD-7 completed during their hospital visit</p> <p>Denominator: # of patients with a main diagnosis of major depression</p> <p>See “Major depression denominator inclusion criteria” for details.</p> <p><b>E2P Update:</b> Beginning December 2024, E2P sites have elected to include a minimum of ‘one’ PHQ-9 during the hospital visit (previously 2 included). This update reflects the preference by clinical teams to utilize the PHQ-9 for screening (all patients) and establish a baseline in relation to shorter inpatient length of stay and likelihood of community-based care following admission.</p>
	Definitions	The GAD-7 is both a screening and validated severity-rating tool. As people with depression may have anxiety as a co-occurring diagnosis, it is recommended that the GAD-7 be administered to people with depression in conjunction with the PHQ-9. The Evidence2Practice Ontario program suggests that the GAD-7 be completed at least once during the person’s hospital stay.
Transitions in Care	<b>E2P Process Indicator</b>	<b>Percentage of people with major depression who have a patient discharge summary upon transitioning from one care provider to another</b>
	Numerator and Denominator	<p>Numerator: # of patients with major depression who have a patient discharge summary completed</p> <p>Denominator: # of patients with a main diagnosis of major depression</p> <p>See “Major depression denominator inclusion criteria” for details</p>
	Definitions	<p>It is important for people with depression transitioning from hospital to home to have a care plan that is shared with them<sup>3</sup>.</p> <p>A patient discharge summary is a form of written communication that accompany the patient after discharge from the hospital<sup>4</sup>. The Evidence2Practice Ontario program mental health discharge summaries sought to align with the principles as outlined by the Patient Oriented</p>

		Discharge Summary (PODS) best practice guidelines <sup>5</sup> . PODS is endorsed by Health Quality Ontario as a recommendation for innovative practices and evidence-informed best practices to improve transitions between hospital and home <sup>4</sup> .
	<b>E2P Process Indicator</b>	<b>Percentage of people with major depression who have their provider discharge summary completed within 48h of discharge</b>
	Numerator and Denominator	<p>Numerator: # of patients with major depression who have a provider discharge summary completed within 48h of discharge</p> <p>Denominator: # of patients with a main diagnosis of major depression</p> <p>See “Major depression denominator inclusion criteria” for details</p>
	Definitions	It is important for people with depression to have a care plan that is shared between providers <sup>3</sup> . A provider discharge summary is a form of written communication for care providers that will provide follow-up care. Created by the most responsible physician (MRP) from the inpatient stay, discharge summaries should be available to the primary care provider (PCP) within 48 hours of hospital discharge. This communication is critical to a patient’s transition because it is relied upon to make ongoing clinical recommendations in their care <sup>4</sup> .
	<b>E2P Process Indicator</b>	<b>Percentage of people with major depression who transition from the inpatient setting to the community who have a booked follow-up appointment with a GP or MH clinician within 7 days of discharge</b>
	Numerator and Denominator	<p>Numerator: # of patients with major depression who have a booked follow up with a primary care provider or mental health clinician within 7 days of discharge</p> <p>Denominator: # of patients with a main diagnosis of major depression</p> <p>See “Major depression denominator inclusion criteria” for details</p>
	Definitions	A follow-up appointment after hospitalization helps support the transition to the community. It is especially important for people with major depression who are admitted to hospital with a



		high risk of suicide to be followed up soon after discharge <sup>3</sup> . Given long wait times to see a GP or psychiatrist across the province, the E2P Ontario program has included mental health clinicians in the process indicator. Also, the program seeks to measure whether the patient has a follow-up appointment scheduled instead of whether the patient went to the appointment due to the availability and feasibility of data collection.
Suicide risk assessment	<b>E2P Process Indicator</b>	<b>Percentage of people with major depression who receive a minimum of two suicide risk assessments during the hospital visit</b>
	Numerator and Denominator	<p>Numerator: # of patients with major depression who have a minimum of 2 suicide risk assessments completed during the hospital visit</p> <p>Denominator: # of patients with a main diagnosis of major depression</p> <p>See “Major depression denominator inclusion criteria” for details</p>
	Definitions	<p>People with major depression have an increased lifetime risk of suicide and should be assessed for suicide risk on initial contact and throughout treatment<sup>6</sup>.</p> <p>A suicide risk assessment includes questions about:</p> <ul style="list-style-type: none"> <li>• Suicidal thoughts, intent, plans, means, and behaviours (hopelessness)</li> <li>• Specific psychiatric symptoms (e.g., psychosis, severe anxiety, substance use) or general medical conditions, as well as psychiatric treatment that may increase the likelihood of acting on suicidal ideas</li> <li>• Past and, particularly, recent suicidal behaviours</li> <li>• Current stressors and potential protective factors (e.g., positive reasons for living, social support)</li> <li>• Family history of suicide or mental illness</li> </ul> <p>Suicide risk assessment scales can be used by trained professionals to guide assessment.</p>

Treatment after initial diagnosis	E2P Process Indicator	Percentage of people with major depression who receive evidence-based psychotherapy during their hospital visit (optional).
	Numerator and Denominator	<p>Numerator: # of patients with major depression who receive evidence-based psychotherapy during their hospital visit</p> <p>Denominator: # of patients with a main diagnosis of major depression</p> <p>See “Major depression denominator inclusion criteria” for details</p> <p><b>E2P Update:</b> This process indicator has been updated as ‘optional’ to reflect differences in treatment availability during inpatient admissions and documentation feasibility.</p>
	Definitions	<p>Both antidepressant medications and evidence-based psychotherapies (such as cognitive behavioural therapy or interpersonal therapy) can be effective treatments for major depression. This indicator measures the percentage of people who receive evidence-based psychotherapy during their hospital stay<sup>2</sup>.</p> <p><b>Evidence-based psychotherapy:</b> includes cognitive behavioural therapy and interpersonal psychotherapy (see below). Other psychotherapies that may be effective include behavioural activation therapy, short-term dynamic psychotherapy, and mindfulness-based cognitive therapy.</p> <p><b>Cognitive behavioural therapy and interpersonal therapy:</b></p> <ul style="list-style-type: none"> <li>• Delivered on a one-to-one or group basis</li> <li>• Delivered over 16 to 20 sessions over 3 to 4 months</li> <li>• Delivered by an appropriately trained therapist in accordance with a treatment manual</li> </ul>
Education and support	E2P Process Indicator	Percentage of people with major depression who are offered information regarding community supports or crisis services during their hospital visit

	Numerator and Denominator	<p>Numerator: # of patients with major depression who are offered information regarding community supports or crisis services during their hospital visit</p> <p>Denominator: # of patients with a main diagnosis of major depression</p> <p>See “Major depression denominator inclusion criteria” for details</p>
	Definitions	<p>People with major depression and their family members and caregivers can benefit from information on services and local supports available in their communities and information on signs and symptoms of relapse<sup>3</sup></p>
	<b>E2P Process Indicator</b>	<b>Percentage of people with major depression who are offered education about major depression during their hospital visit (optional).</b>
	Numerator and denominator	<p>Numerator: # of patients with major depression who are offered information regarding community supports or crisis services during their hospital visit</p> <p>Denominator: # of patients with a main diagnosis of major depression</p> <p>See “Major depression denominator inclusion criteria” for details</p> <p><b>E2P Update:</b> This process indicator has been updated as ‘optional’ to reflect differences in treatment availability during inpatient admissions and documentation feasibility.</p>
	Definitions	<p>Education includes the following topics<sup>3</sup>:</p> <ul style="list-style-type: none"> <li>• Signs and symptoms of depression</li> <li>• Treatment options and their side effects</li> <li>• Self-management strategies such as monitoring symptoms and suicide risk, participating in meaningful activity, eating well, practicing sleep hygiene, performing physical activities, and reducing tobacco and alcohol use</li> <li>• Family self-care and resilience</li> <li>• Local resources for support</li> <li>• Risk of relapse, and early signs and symptoms of relapse</li> </ul>

## Anxiety Indicators – Inpatient

### Overall approach

The below includes a compilation of process indicators that can be measured for people with a main diagnosis of **an anxiety disorder**. These indicators focus on the inpatient setting and were created based on the [Anxiety Disorders Quality Standard](#). These indicators are relevant to the main quality statements implemented, or E2P Ontario pilot sites have deemed that the indicator is measurable within Health Information Systems and valuable to collect for quality improvement opportunities. Reasons for not including indicators include them being patient self-reported, beyond the time frame of this project, not documented in HIS' and more.

### Anxiety disorders denominator inclusion criteria

- For diagnosis type, use Q2A with DSM-V to reflect the principal diagnosis.
- Age  $\geq$  18 years
- During the hospital visit: between registration and discharge
- Your indicator denominator/patient cohort can be pulled from the data captured in the RAI

Diagnosis	ICD-10-CA
Phobic anxiety disorders	F41.0
Generalized anxiety disorder	F41.1
Mixed anxiety and depressive disorder:	F41.2
Anxiety Disorder, unspecified	F41.9

Screening	E2P Process Indicator	Percentage of people with an anxiety disorder who receive a minimum of one PHQ-9 during their hospital visit
Comprehensive assessment	Numerator and Denominator	<p>Numerator: # of patients with an anxiety disorder who have 1 PHQ9s completed</p> <p>Denominator: # of patients with an anxiety disorder as their main diagnosis</p> <p>See “Anxiety Disorder Denominator” for details.</p> <p><b>E2P Update:</b> Beginning December 2024, E2P sites have elected to include a minimum of ‘one’ PHQ-9 during the hospital visit (previously 2 included). This update reflects the preference by clinical teams to utilize the PHQ-9 for screening (all patients) and establish a baseline in relation to shorter inpatient length</p>

		of stay and likelihood of community-based care following admission.
	Definitions	The PHQ-9 is a validated tool for assessing the severity of symptoms and degree of functional impairment. As people with anxiety have depression as a co-occurring diagnosis, it is recommended that the PHQ-9 be administered to people with an anxiety disorder in conjunction with the GAD-7. The PHQ-9 is one component of a comprehensive assessment <sup>1</sup> . Frequent measurement of symptoms using the PHQ-9 allows providers to know when the patient is having a full response, partial response, or no response to treatment. This information helps in making decisions about how to adjust treatment. There are no strict guidelines on how often the PHQ-9 should be re-administered in an inpatient setting <sup>2</sup> . The Evidence2Practice Ontario program suggests that the PHQ-9 be completed at least once during the person's hospital stay.
	E2P Process Indicator	<b>Percentage of people with an anxiety disorder who receive a minimum of one PHQ-9 during their hospital visit</b>
	Numerator and Denominator	<p>Numerator: # of patients with an anxiety disorder who have 1 PHQ9s completed during their hospital visit</p> <p>Denominator: # of patients with an anxiety disorder as their main diagnosis</p> <p>See “<i>Anxiety disorders denominator inclusion criteria</i>” for details.</p> <p><b>E2P Update:</b> Beginning December 2024, E2P sites have elected to include a minimum of ‘one’ PHQ-9 during the hospital visit (previously 2 included). This update reflects the preference by clinical teams to utilize the PHQ-9 for screening (all patients) and establish a baseline in relation to shorter inpatient length of stay and likelihood of community-based care following admission.</p>
	Definitions	The GAD-7 is both a screening and validated severity-rating tool. By itself, identification does not provide a diagnosis of an anxiety disorder; however, it does provide preliminary documentation of symptoms and quantify severity in a time-limited setting, and it

		<p>indicates who may need further assessment<sup>2</sup>. The GAD-7 is a validated severity-rating tool that can be used as one component of a comprehensive assessment. The E2P Ontario program focuses on the administration of the GAD-7 as it can be used for general anxiety disorder, and often a starting point for measurement-based care in people with other anxiety disorders. The Anxiety Quality Standard has a list of other validated severity-rating tools that can be used for other anxiety disorders in conjunction with the GAD-7. The Evidence2Practice Ontario program suggests that the GAD-7 be completed at least once during the person's hospital stay.</p>
Transitions in Care	<b>E2P Process Indicator</b>	<b>Percentage of people with an anxiety disorder who have a patient discharge summary upon transitioning from one care provider to another</b>
	Numerator and Denominator	<p>Numerator: # of patients with an anxiety disorder who have a patient discharge summary completed</p> <p>Denominator: # of patients with an anxiety disorder as their main diagnosis</p> <p>See "Anxiety disorders denominator inclusion criteria" for details</p>
	Definitions	<p>It is important for people with an anxiety disorder transitioning from hospital to home to have a care plan that is shared with them. A patient discharge summary is a form of written communication that accompany the patient after discharge from the hospital<sup>4</sup>. The Evidence2Practice Ontario program mental health discharge summaries sought to align with the principles as outlined by the Patient Oriented Discharge Summary (PODS) best practice guidelines<sup>5</sup>. PODS is endorsed by Health Quality Ontario as a recommendation for innovative practices and evidence-informed best practices to improve transitions between hospital and home<sup>4</sup>.</p>
	<b>E2P Process Indicator</b>	<b>Percentage of people with an anxiety disorder who have their provider discharge summary completed within 48h of discharge</b>
	Numerator and Denominator	<p>Numerator: # of patients with an anxiety disorder who have a provider discharge summary completed within 48h</p>

		<p>Denominator: # of patients with an anxiety disorder as their main diagnosis</p> <p>See “<i>Anxiety disorders denominator inclusion criteria</i>” for details</p>
	Definitions	<p>It is important for people with an anxiety disorder to have a care plan that is shared between providers. A provider discharge summary is a form of written communication for care providers that will provide follow-up care. Created by the most responsible physician (MRP) from the inpatient stay, discharge summaries should be available to the primary care provider (PCP) within 48 hours of hospital discharge. This communication is critical to a patient’s transition because it is relied upon to make ongoing clinical recommendations in their care<sup>4</sup>.</p>
Cognitive behavioural therapy	<b>E2P Process Indicator</b>	<b>Percentage of people with GAD who receive cognitive behavioural therapy during their hospital visit (Optional)</b>
	Numerator and Denominator	<p>Numerator: # of patients with an anxiety disorder who receive cognitive behavioural therapy during their hospital visit</p> <p>Denominator: # of patients with an anxiety disorder as their main diagnosis</p> <p>See “<i>Anxiety disorders denominator inclusion criteria</i>” for details</p>
	Definitions	<p>Psychological treatments play an important role in the management of anxiety disorders. Cognitive behavioural therapy (CBT), a type of psychotherapy, is an effective treatment for anxiety disorders when delivered by a trained health care professional. See Quality Statement 6: Cognitive Behavioural Therapy, for a more detailed description of CBT<sup>7</sup>.</p> <p><b>E2P Update:</b> This process indicator has been updated as ‘optional’ to reflect differences in treatment availability during inpatient admissions and documentation feasibility.</p>



## Depression & Anxiety Process Indicators – Outpatient

The below includes a compilation of process indicators that can be measured for people with an anxiety disorder or mood disorder. These indicators focus on the **outpatient setting** and were created based on the Major Depression Quality Standard and Anxiety Quality Standard. These indicators are relevant to the main quality statements implemented and are relevant for people with anxiety disorders and/or other mood disorders. The outpatient setting does not leverage the Resident Assessment Intake form or use CIHI's coded diagnoses, so the patient cohort will include all patients who had an outpatient visit at a clinic that supports people with anxiety and/or mood disorders. These metrics will provide insight into clinic services as a whole, instead of being stratified according to people with major depression and anxiety disorders.

*Outpatient clinic inclusion criteria:*

- Clinic supports people with anxiety and/or mood disorders
- The total number of unique patients who had a registered visit at the outpatient clinic
- Use the most recent visit for the unique patient

Comprehensive assessment	E2P Process Indicator	Percentage of people who had a registered visit for the [outpatient clinic] that received a PHQ-9 at least once in the past 6 weeks
	Numerator and Denominator	<p>Numerator: # of people who received a PHQ-9 at least once in the past 6 weeks</p> <p>Denominator: # of people who had a registered visit at the [outpatient clinic] during the month of reporting</p> <p>See <i>outpatient clinic inclusion criteria</i> for more details</p>
	Definitions	<p>The PHQ-9 is a validated tool for assessing the severity of symptoms and degree of functional impairment. It is one component of a comprehensive assessment.<sup>1</sup> Repeated measurement of symptoms using the PHQ-9 allows providers to know when the patient is having a full response, partial response, or no response to treatment. This information helps in making decisions about how to adjust treatment. There are no strict guidelines on how often the PHQ-9 should be re-administered in an outpatient setting. However, there is some guidance on re-administering the tool at 4-6 weeks to measure response to treatment.<sup>2</sup> The PHQ-9 may be administered more frequently based on</p>

		organizational policies and clinical judgment, but the Evidence2Practice program will measure that a PHQ-9 score has been done within 6 weeks of the patient's outpatient appointment.
	<b>E2P Process Indicator</b>	<b>Percentage of people who had a registered visit for the [outpatient clinic] that received a GAD-7 at least once in the past 6 weeks</b>
	Numerator and Denominator	<p>Numerator: # of people who received a GAD-7 at least once in the past 6 weeks</p> <p>Denominator: # of people who had a registered visit at the [outpatient clinic] during the month of reporting</p> <p>See <i>outpatient clinic inclusion criteria</i> for more details</p>
	Definitions	The GAD-7 is both a screening and validated severity-rating tool. As people with depression may have anxiety as a co-occurring diagnosis, it is recommended that the GAD-7 be administered to people with depression in conjunction with the PHQ-9. The Evidence2Practice program will measure that a GAD-7 score has been done within 6 weeks of the patient's outpatient appointment.
Transitions in Care	<b>E2P Process Indicator</b>	<b>Percentage of people discharged from the [outpatient clinic] who have a patient discharge summary/patient treatment plan upon completion of treatment (Optional)</b>
	Numerator and Denominator	<p>Numerator: # of people who have a patient discharge summary/patient treatment plan upon completion of treatment</p> <p>Denominator: # of people discharged from the outpatient clinic during the month of reporting</p> <p>See <i>outpatient clinic inclusion criteria</i> for more details</p> <p><b>E2P Update:</b> This process indicator has been updated as 'optional' for organizations who may not have outpatient discharge summaries.</p>
	Definitions	It is important for people with depression transitioning from hospital to home to have a care plan that is shared with them, and the E2P program recommends that patients who complete treatment in an outpatient setting receive a patient discharge summary or patient

		<p>treatment summary as well <sup>3</sup>. Though there will be nuanced differences between an outpatient discharge summary and inpatient discharge summary, the document is still a form of written communication that accompanies the patient after they complete their treatment. The Evidence2Practice Ontario program outpatient mental health discharge summaries sought to align with the principles as outlined by the Patient Oriented Discharge Summary (PODS) best practice guidelines<sup>5</sup>. PODS is endorsed by Health Quality Ontario as a recommendation for innovative practices and evidence-informed best practices to improve transitions between hospital and home<sup>4</sup>.</p>
	<b>E2P Process Indicator</b>	<b>Percentage of people discharged from the [outpatient clinic] who have their provider discharge summary completed within 7 days of discharge (Optional)</b>
	Numerator and Denominator	<p>Numerator: # of people who have a provider discharge summary completed within 7 days of completion of treatment</p> <p>Denominator: # of people discharged from the outpatient clinic during the month of reporting</p> <p>See <i>outpatient clinic inclusion criteria</i> for more details</p> <p><b>E2P Update:</b> This process indicator has been updated as 'optional' for organizations who may not have outpatient discharge summaries.</p>
	Definitions	<p>The guidelines state clearly that it is important for people with depression to have a care plan that is shared between providers<sup>3</sup>. A provider discharge summary is a form of written communication for care providers that will provide follow-up care. In an outpatient setting, this practice is less standardized. As transitions in care have been identified as an area of focus and a pain point for people with anxiety and depression, the E2P program encourages outpatient settings to standardize the practice of completing provider discharge summaries.</p>

## Terminology Mapping Pre-Setup

### Reporting CCL Templates

#### Inpatient:



1\_XV\_e2p\_IP\_prg.txt



1\_XV\_e2p\_IP\_dpb.txt

#### Outpatient:



1\_XV\_e2p\_OP\_prg.txt



1\_XV\_e2p\_OP\_dpb.txt

### SNOMED Summary

The following report guide is intended to support Oracle hospitals in Ontario to map clinical concepts to Systematized Nomenclature of Medicine — Clinical Terms (SNOMED CT) and develop a report to measure adherence to the process indicators.

SNOMED CT is a systemically organized computer processable collection of medical terms. These coded terms can be used within Health Information Systems to capture, record, and share clinical data. Standardized reporting that pulls from clinical concepts mapped to SNOMED CT codes enables comparison of standard adherence across different hospitals and different health information systems, equips organizations with valuable data that drives quality improvement initiatives, and provides the opportunity to learn from peer hospitals.

As hospitals have different Health Information Systems (e.g., Oracle, EPIC, and Meditech) that have different concepts for clinical terms that have the same (or similar) meaning, mapping clinical concepts to the same SNOMED CT code provides a common link that enables comparison.

Depending on the organization, this toolkit will serve as a guide for Oracle database administrators responsible for codesets and Cerner Command Language (CCL) report writing. Modifications may need to be made to the report at each hospital level. The project timeframe may vary across hospitals depending on available resources and state of readiness. The hospitals that participated in the initial SNOMED CT Mapping and Reporting went live within 6 months of initiation.

# Terminology Mapping Pre-Setup



## Purpose

Contributor source alias and semantic tags are to be used in translation reports



## IDEA

Design drawn from how NHS structured their SNOMED CT mapping

CONTRIBUTOR SOURCE Alias (E2P\_SNOMED): used to map the SNOMED CT code

## HOW TO CREATE THE CONTRIBUTOR SOURCE ALIAS: E2P\_SNOMED

### Step 1: Create CDF Meaning

Open Core Code Builder

Search for code set **73**

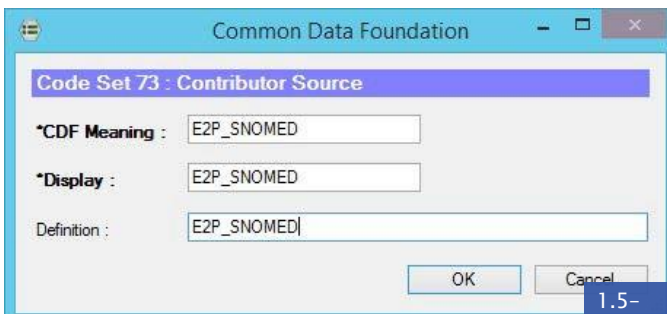
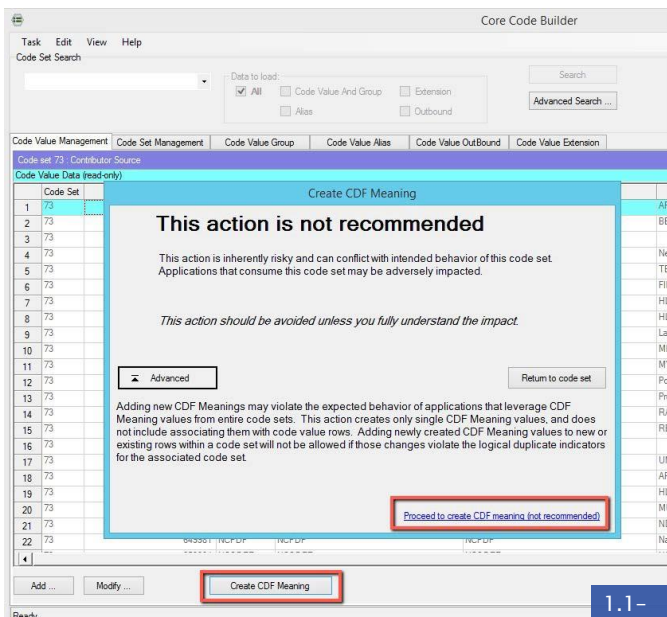
Select **Create CDF Meaning**

This opens a new window with a Create CDF meaning warning

Select **Proceed to create CDF meaning (not recommended)**

Enter **E2P\_SNOMED** for CDF Meaning, display and definition.

Select **OK**



# Terminology Mapping Pre-Setup

Codesets used

72 Event

Code Value Management

Code Set 73 : Contributor Source

Code Value 2696207233 : E2P\_SNOMED

Code Value    Code Value Inbound    Code Value Outbound    Code Value Extension

\*Display: E2P\_SNOMED

Display key: E2PSNOMED

Description: E2P\_SNOMED

Definition: E2P\_SNOMED

CDF meaning: E2P\_SNOMED Add ...

CKI:

Concept:

Begin effective dt tm: 12-Oct-2022

\*End effective dt tm: 31-Dec-2100

Collation sequence: 0

☒ Active

New OK Cancel Apply

2.1-2.2

Step 2: Create a new alias codevalue in codeset 73: Contributor Source

Open Corecodebuilder

2.1

Create the codevalue **E2P\_SNOMED** and attach the created CDF meaning of **E2P\_SNOMED**

2.2

HOW TO CREATE THE CODE VALUE EXTENSION: E2P

Open Corecodebuilder

Load the codeset (i.e., 72 )

Click on the **Code Value Extension** tab

Click **Code Set Extension** button

Type:

Field Name: **E2P**

Field Type: **AlphaNumeric**

Select

OK

Codesets used		
72	Event	4001

PRE-REQUISITE

Step 1: [See table](#) with the terminology, corresponding SNOMED CT code, and semantic tags

MAPPING STEPS

Step 2: Follow the steps below to execute terminology mapping to SNOMED CT in Cerner







- 1.1 Open CoreCodeBuilder
- 1.2 Load the codeset where the term is found (e.g., 72 )
- 1.3 On the Code Value Management tab:
- 1.4 Search for the code value that requires SNOMED CT code mapped and double click to open the Code Value Management window
- 1.5 Click on Code Value Outbound tab





# Viewing Mapped SNOMED CT code and Semantic Tags<sup>9</sup>

Viewing mapped codes and semantic tags can be easily viewed in the main window of corecodebuilder

Code Value Management		Code Set Management		Code Value Group		Code Value Alias		Code Value OutBound		Code Value Extension	
Code set 72 : EVENT_CODE											
Filter by											
<input checked="" type="radio"/> Contributor Source:		E2P_SNOMED		<input type="radio"/> Code Value Display				<input type="button" value="Clear Filter"/>			
	Contributor Source		Alias		Code Value		Code Value Display		CDF Meaning		Act
1	E2P_SNOMED		363808001		4154120		Weight Measured				
2	E2P_SNOMED		364202003		710254		Urine Voided				
3	E2P_SNOMED		364202003		2557317227		Nephrostomy Tube Output:				
4	E2P_SNOMED		364202003		2567001607		Urinary Catheter Total Output				
5	E2P_SNOMED		423475008		3362628		Heart Failure Education Topics				
6	E2P_SNOMED		721917003		2820588		Discharge Summary				

1.1

Code Value Management	Code Set Management	Code Value Group	Code Value Alias	Code Value OutBound	Code Value Extension
Code set 72 : EVENT_CODE					
Code Set Extension ...					
	Code Value	Code Value Display		E2P	
1	2820588	Discharge Summary	RECORD ARTIFACT		
2	3362628	Heart Failure Education Topics	PROCEDURE		
3	2557317227	Nephrostomy Tube Output	OBSERVATION		
4	710254	Urine Voided	OBSERVATION		
5	4154120	Weight Measured	OBSERVATION		
6	2567001607	Urinary Catheter Total Output	OBSERVATION		

## VIEWING SNOMED CT CODE

Load the codeset

Click on the **Code Value Outbound** tab

Filter by Contributor Source:  
**E2P\_SNOMED**

Click on the Alias column to sort  
the codes to the top

## VIEWING SEMANTIC TAG

Click on the **Code Value Extension** tab

Click on the E2P Column to sort the  
semantic tags to the top

Choosing the SEMANTIC tag

Consulted with Canada Health Infoway (CHI) and referenced 2-ELP0025\_ContentHierarchyIntroduction to understand each hierarchy's content for correct semantic tag use. [See appendix](#) for the guide to understand the hierarchy

Choosing the CODESET

Selected codesets based on clinical workflow and report output

## QUALIFIER

Qualifier values represent the values of some of the SNOMED CT attributes, where those values are not subtypes of another top-level concept. For example, 'left', 'severe', or 'capsule'. Qualifier values are used in health record to define the laterality of a diagnosis or procedure (such as 'left', 'right' or 'bilateral'), the severity of a condition (for example, 'severe'), the priority of a procedure (for example 'emergency'), a medication dose form (like 'tablet' or 'capsule') and a route of administration (such as 'oral' or 'topical').

## MEDICINAL\_PRODUCT

Pharmaceutical/biologic products are medication products or drugs. They include concepts that describe a type of medication at various levels of detail. The MEDICINAL\_PRODUCT hierarchy falls under the Pharmaceutical/biologic products hierarchy.

## PROCEDURE

Procedures represent activities performed in the provision of health care. This includes not only surgical procedures (such as Appendectomy), but also the administration of medicine (such as the administration of anesthesia), imaging (such as 'x-rays' and 'ultrasounds'), education (such as diabetic care education), therapies (like physiotherapy) and administrative procedures (like 'admission' or 'discharge'). Procedures are frequently documented in a health record. The most common reasons to do so are to record the procedures that have been performed (for example during a hospital stay), to record the procedures that are planned (such you may find in a care plan), or to record a procedure that is being ordered or requested.

## OBSERVATION

Observable entities are things that can be observed. They represent a question or an assessment, which can produce an answer or result. Observable Entities and Clinical Findings often work together, because the Observable Entity represents the question, while the Clinical Finding represents the answer. Examples of observable entities include 'systolic blood pressure', 'color of iris', and 'gender'. Concepts in this hierarchy are used to represent the name or type of an observation. Other code systems, such as LOINC, can also be used for this purpose.

## THERAPY

Regime/therapy (subtype of procedure): set of procedures focused on a single purpose on one patient over time (e.g. repeated administration of drug in a small dose for an indefinite period of time).

## RECORD\_ARTIFACT

Record artifacts represent content that is created to provide people with information about record events or states of affairs. Examples include a 'patient held record', a 'discharge summary', a 'record entry', a 'family history section on a report', and a 'birth certificate'. Record artifact concepts are used in health records to document the type of identification used by a patient, or to specify the type of document used or required.

Item or Concept	SNOMED CT (EP2)	Sample HIS Term	CODESET	Code Value Extension or Semantic Tag
PHQ-9	720433000	PHQ-9 score Total severity score	72	Observable entity
GAD-7	445455005	GAD7 score	72	Observable entity
Patient discharge summary	38451000087100	Patient discharge note Discharge instructions Inpatient patient summary	72	Record artifact
Provider discharge summary	373942005	Discharge summary (MH) Discharge summary, psychiatry discharge note	72	Record artifact
Follow up appointment	1156892006	TBD	72	Procedure
Suicide risk assessment	3161000175102	Suicide Ideation	72	Observable entity
Evidence-based psychotherapy	75516001	Therapy name (inpatient) Social work documentation (form)	72	Regime/therapy
Community supports	710822009	Special services and community resources Recommended supports team	72	Procedure
Crisis services	408904007	Crisis safety plan (form)	72	Procedure
Mental health care education	410224008	Education provided during encounter Ed – depression	72	Procedure
Cognitive behaviour therapy	228557008	Social work documentation (text)	72	Regime/therapy

## References

1. <https://www.hqontario.ca/Evidence-to-Improve-Care/Quality-Standards/View-All-Quality-Standards/Major-Depression/Quality-Statement-1-Comprehensive-Assessment>
2. [https://www.health.ny.gov/health\\_care/medicaid/redesign/dsrip/2016-07-01\\_phq\\_2\\_and\\_9\\_clean.htm#ix](https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/2016-07-01_phq_2_and_9_clean.htm#ix).
3. <https://www.hqontario.ca/Portals/0/documents/evidence/quality-standards/qs-anxiety-disorders-quality-standard-en.pdf>

