PQRS Summary

PQRS is the Physician Quality Reporting System. We may all argue with how much "Quality" comes out of this program, but it is the gorilla in the room when it comes to billing and payments.

CMS will use the 2015 data to determine payments in 2017 – and if we do not meet the 50% benchmark for every measure, we stand to lose 2.5% of Medicare payments in 2017 – for EVERY doctor/NP/PA visit in PrimaCARE – specialist and PCP.

So – that is the motivation behind all this work. Some of it is busy work – I certainly do not argue that much of this is meaningful, in the best interest of the patient, or practical office-based medicine.

So what are the measures and how do we meet them?

1. Hemoglobin A1c (measure 1) – Percentage of patients aged 18-75 with diabetes whose A1c > 9% (representing poor control).

How we measure: The A1c results ordered/resulted in our lab will be tracked – you don't have to do anything special. However, the transition to a new lab interface recently has renamed this test – Ernst is working on a fix for this reporting problem. If an A1c is done outside of PC, it needs to be entered in the system via the alert system. More on this later if you don't know what this means.

2. CAD and antiplatelet therapy (measure 6) – Percentage of patients aged 18 and older with CAD who were prescribed aspirin or Plavix. This is tracked automatically via the med list and problem list. You don't need to do anything except prescribe the appropriate medication for this problem.

3. Urinary incontinence (measure 48) – Assess the presence or absence of incontinence – not too difficult – one question takes care of it. BUT it is only tracked in Preventive Medicine. Sorry, but this is where you MUST record it. You can be a stellar doctor, asking all the right questions – but if it is not recorded in Preventive Medicine, no one will see it. If a bear leaks urine in the forest and it is not recorded in Preventive Medicine, then the bear never leaked any urine.
Note that you do not NEED to do anything BUT document that the patient is continent or incontinent of urine. In your note, you can address this further, but for PQRS, nothing more is needed.

4. Influenza immunization (measure 110) – Percentage of patients age 6 months and older seen for a visit from October to March who received an influenza immunization OR reported previous receipt of an influenza immunization. IF this is recorded properly in the "Immunization" section – we are covered. You should also record if the patient DECLINED the flu vaccine – there is an entry option in "Immunization" to record this.

5. Pneumococcal vaccination status (measure 111) – Percentage of patients over age 65 who ever received a pneumococcal vaccine (PPSV23 or PCV13). Again, if this is recorded properly in "Immunization" - your work is done. You should also document if the patient DECLINED the PPSV23 or PCV13.

6. Breast cancer screening (measure 112) – Percentage of women aged 50 to 74 who have had a mammogram in the past 27 months. If this is recorded properly in the alert system – your work is done. If it is done at PC, you don't need to do anything more. If it is done outside of PC, it should be scanned and then linked to the alert system. More on this later if you don't know that this means.

7. Colorectal cancer screening (measure 113) – Percentage of patients age 50 to 75 who had "appropriate" screening for colorectal cancer. IF this is recorded under "colonoscopy" or "FIT/FOBT-CHEK" - you are covered. If the fecal immunochemical testing is done in PC, you are all set. If our GI team does the colonoscopy, you are all set. IF someone else does the colonoscopy, you need to scan it and link it to the alert system. More on this if you don't know what this means.

8. BMI (measure 128) – Percentage of patients aged 18 and older with BMI documented in an encounter in the past 6 months AND with BMI outside of normal parameters (22 to 30) with a follow-up plan documented. If the BMI is between 22 and 30, you have to do NOTHING else – this is tracked from the VS part of ECW. I the BMI is < 22 or > 30 – you need to address it. This is set up in the "Preventive Medicine" section as:

BMI greater than 30
dropdown menu = Diet and/or exercise counseling provided to the patient
BMI less than 22
dropdown menu = Diet counseling provided to the patient

If you record this outside of "Preventive Medicine", it does not count for PQRS. Continue to provide your counseling and patient education materials to help patients with weight problems – but you MUST record the simple data described above in the structured fields in "Preventive Medicine" for it to be extracted and recorded properly to CMS. There is a box next to the dropdown menu to put in details if you wish – or you can record them elsewhere in your note.

9. Documentation of current medications (measure 130) – Percentage of patients aged 18 and older for which the eligible professional attests to documenting a list of current medications – this must include OTC/herbals as well as doses/frequency/route of administration. If you or your "certified" MA is hitting the "verified" box for medication reconciliation – you are covered.

10. Fall Risk Assessment (measure 154) and Plan of Care (measure 155) – The risk assessment looks at the number of patients with a risk assessment (numerator) among all those with a risk of falls (denominator). So the first part is simply asking – does the patient have a risk of falls, which CMS defines as those with past falls. I have boiled this down to TWO questions:

- No falls in the past year, OR only one fall WITHOUT injury in the past year – **NEGATIVE and you are done with this entire set of measures.**
- Two or more falls in the past year without sustaining an injury OR one fall in the past year with injury – **this is a POSITIVE – and you must proceed to to the second set of dropdown menus as well as to measure 155 below**:

The first dropdown menu – choose ONE (you can do more, but choose one to document)

- Home fall hazard assessment (we will set up a questionnaire for the offices that wish it - the patient answers a few simple questions about lighting, throw rugs, bathtub/shower mats, handrails)
- Vision tested
- Postural blood pressure tested
- Medications reviewed to assess possible contribution to falls in the past 12 months

The second dropdown menu – choose ONE

- Gait and balance tested and found to be normal
- Gait and/or balance testing identified the patient to be a increased risk for falls

IF the patient does have a history of falls, measure 155 also needs to be completed. **If there is no risk of falls, the next measure can be ignored.** This is called “Falls: Plan of Care”:

- Vitamin D supplementation discussed, AND balance, strength, and gait training discussed
- Vitamin D supplementation discussed, AND patient referred to an exercise program
- Vitamin D supplementation discussed, AND patient referred to physical therapy

CMS does not require you to prescribe vitamin D – only discuss it. The plan is entirely up to you – but CMS does require that you document your awareness of the risk, and that you have done some counseling or referrals to try to reduce future falls. The medicine behind this is reasonable – the documentation constraints are a bit onerous.

This PQRS measure is a bit messy. You have to jump through these hoops AND record this in “Preventive Medicine” to meet this requirement. The template I am describing has not yet been implemented – but it should be available very soon. It will be found in “Preventive Medicine”, and it must be completed for at least 50% of our patients over age 65. This is, in my view, the most onerous of the measures to document. It does not matter if you recognize your patients at risk for falls, and counsel them about handrails, good lighting, getting rid of throw rugs, and send them to PT for gait training – if you don't document it in “Preventive Medicine”, it does not count.

11. Diabetic foot exam (measure 163) – This measure requires visual inspection of the foot, testing sensation with a monofilament, and assessing pulses – everything that we do already. BUT unless you record this in “Preventive Medicine”, it does not count. We are setting up a new template in “Preventive Medicine” that includes very simple dropdown menus.

Patient is not a diabetic – if you document this, you are done.

Three dropdown menus:

- Foot inspection normal
- Foot inspection abnormal

- ✔ Monofilament testing normal
- ✔ Monofilament testing abnormal

- ➢ Pulses in feet normal
- ➢ Pulses in feet abnormal

I thought about putting all this in one dropdown, but it would get very “busy” - for example “Inspection abnormal, Monofilament normal, Pulses abnormal” would be one of multiple entries. I think breaking it down into 3 simple dropdowns is easier.

There is a box next to each of these where you can record your findings – but this is NOT necessary for PQRS. All that is necessary is that you document the structured data (the dropdown box information).

The first entry (“Patient is not a diabetic”) is the exclusion data – CMS requires all patients to have data – whether they are diabetic or not. If the patient is not a diabetic, just say so, and you are done.

IF the patient is a diabetic, complete the other entries.

We are going to set up a “default” button for this entire “Preventive Medicine” folder that will answer all questions with the simplest/healthiest choices. You need to go in and alter the answers when they are positive. We will provide more detail on this option as soon as the templates are all set up.

You may do this in your note – but it doesn't count unless done in “Preventive Medicine”. If you don't want to record it twice, just use the “Preventive Medicine” as your physical exam for diabetic feet. The good news (for me, anyway) is that using the caret (the little upside down triangle next to many of the elements in your visit templates), you can import this data into subsequent visits – a good way to keep track of the prior exam.

12. Tobacco Use (measure 226) – If you are using the Smart Form – you are covered. But if they are smokers, you need to document in the smart form that counseling was provided.

13. Controlling HTN (measure 236) – Percentage of patients age 18 to 85 who have a diagnosis of HTN and whose BP is < 140/90. As Dr. Fogle has pointed out repeatedly – AVOID rounding to 140 and 90 – if the BP is 138/89 – you are good – if it is 140/90 – forget it!

Adding data to the alert system: I have mentioned this a few times. Say that John Doe has a colonoscopy done at CMH by Dr. Berman – this will not get into ECW without someone scanning the procedure note. The next step after this is crucial to “get credit” for the colonoscopy. There is a button in the scanning box called “Manage Alerts” that will take you to CDSS/Alerts. There, you can enter the colonoscopy into the alert for colorectal screening. The workflow for doing this will be reviewed in an upcoming newsletter. This system is working for some things, but not for others. This is a HUGE priority for me – I am working with MJ, Ernst, and ECW to try to get our alert system functioning smoothly.

I realize this is a very complicated and long update – but I think there has been a lot of confusion about PQRS. As of TODAY, this is what I understand to be the requirements and suggested workflows for recording the necessary data in ECW to meet the benchmarks for PQRS. The templates for the PQRS folder in “Preventive Medicine” are in development (and we are working with Steward on some overlap issues between PQRS and ACO measures), and the alert system for screening tests is still broken, and we are working with ECW to repair this ASAP. The struggle continues, and we will continue to pressure ECW to make our implementation of ECW WORK for us!

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