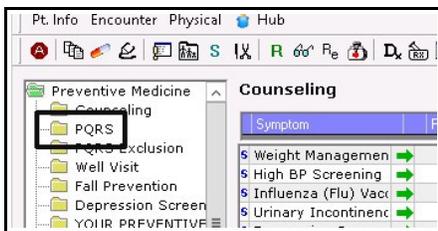


ECW How To PQRS in Preventive Medicine

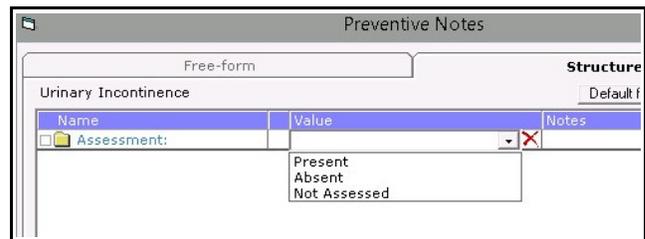
I will preface this “How To” with the observation that this process is clunky – it takes me out of my usual workflow during an office visit (as do many processes in ECW). I have explained in the past why PQRS is important to us all, and am the first to admit that this approach to documenting PQRS is suboptimal. But given the limitations with what we have to work with in ECW, the requirements of CMS, and need to be able to “mine” this data from structured fields – what I present here is the best I can come up with. I do not know how to program in ECW (nor do I have that authority) – so I must rely on what ECW tells Ernst and MJ what is possible.

Most of the PQRS measures are fulfilled with lab data, DI data, medications lists, immunizations, and vital signs (see the email outlining PQRS – this can also be found at http://www.drkney.com/html_pages/ecw.htm). However, a

few are HPI elements or exam elements – that cannot be extracted from our notes. We have to put the data in structured fields created in “Preventive Medicine” (see the screenshot to the right) within the folder called “PQRS” (see the screenshot to the left).



Let's start with the simplest – **urinary incontinence**. This is measure 48 – it is being retired this year in favor of measure 50 – which requires a plan of care for women who are incontinent. But for measure 48, the numerator is simply women in whom incontinence is assessed as being present or absent, with the denominator being all women 65 and older. It is a very simple measure. No plan of care NEEDS to be documented here – though you may certainly use the “Notes” section to record a plan of care or other comments. When the creation of all the structured fields for PQRS is completed, we hope to have a default button set up so all the entries can be populated with the simplest answers – for this, we would populate it with “Absent” - and you would need to correct it manually if this choice were incorrect. We DO NOT have this set up so far – but look for it in the near future. For now, you need to go to EACH folder in PQRS (where appropriate) and select the correct responses.



Next – **BMI counseling**. IF the BMI is between 23 and 30, the patient is automatically excluded from this measure. You do NOT need to do ANYTHING. However, if the BMI is < 23 or > 30, you need to select some very simple responses. Note that the BMI references above are for patients age 65 and older. If you have Medicare patients under age 65 (many patients on disability are on Medicare), the BMI range is < 18.5 or > 25.

The screenshot on the right shows all you need to do if the BMI is greater than 30 (for those 65+) or greater than 25 for those under age 65. The first response satisfies CMS.



If the patient's BMI is under 23 for anyone age 65 or older, or under 18.5 for younger patients, the screenshot at the left shows an appropriate response. Provide these patients with whatever diet/exercise guidance you want, just document that you did something.

CMS requires that you document a plan at the current visit when the BMI is documented as being out of range, or “during the previous 6 months of the current encounter”.

The next entry is a little more complicated – the **diabetic foot exam**. The pertains to all diabetics from age 18 to 75 (on Medicare). It requires assessment of pulses, assessment of sensation (it specifically states “with monofilament”), and inspection of the foot. First, choose the date – the first line in the screenshot to the right. Then choose pulses, and choose a response. I no longer document the diabetic foot exam in my “Examination” - I use the “Preventive Medicine” area – under “PQRS”. This saves me documenting things twice. In the “Notes” section the right of the structured field, I document the details – like “DP 2+ on right, but absent on left” - what you choose to put in the structured field box when the pulses are different on one foot

versus the other is up to you – I enter the worst finding in the structured field box. So in the case above, I would enter “absent”.

Sensation is done in pretty much the same way. I also use the “Notes” section here to document greater detail.

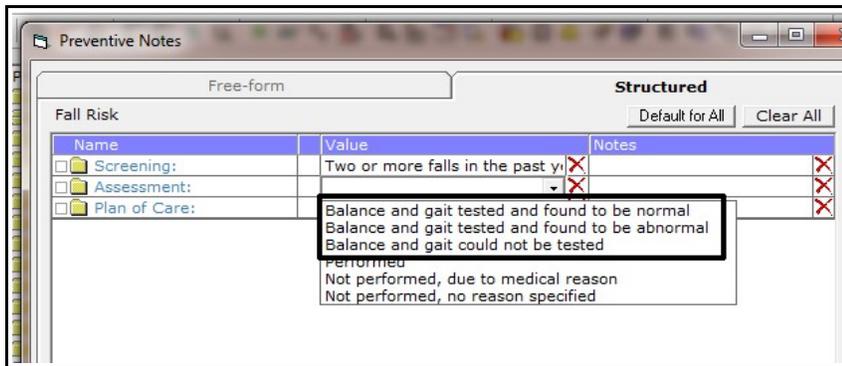
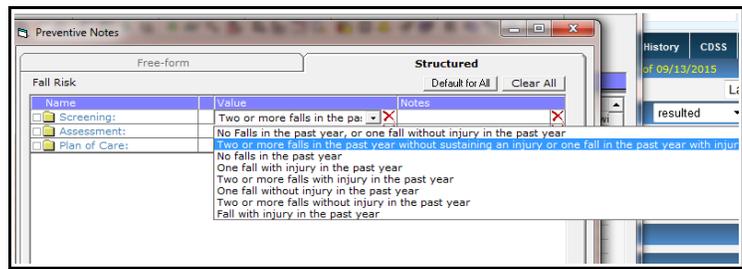
Visual exam follows the same workflow. If it is abnormal, I add details in the “Notes” section. This is obviously a bit cumbersome – but the nice thing is that this can be pulled into your notes visit after visit – so you can easily recall when you last did a complete diabetic foot exam.

Using the caret (see the dark circle around the caret to the left), I was able to pull all the PQRS data into this note – it also includes the details in the “Notes” section, making this a pretty useful way to follow the

diabetic foot exam as well as other screens (you can see this patient did not fall in the past year, and is not incontinent).

Fall risk assessment and plan of care: This is a rather complicated measure (154 and 155). This pertains to all patients aged 65 or greater (on Medicare). If the patient has not fallen, or fallen only once “without injury” - then they are excluded from the rest of the measure, and you can STOP.

The screenshot to the right shows the options. The reason there are so many options has to do with the development of this measure in the past. Once it is set up, we cannot delete anything without deleting previous data. So choose either the first, third, or sixth option to exclude the patient from further questions. The first entry was set up to cover both exclusion criteria.

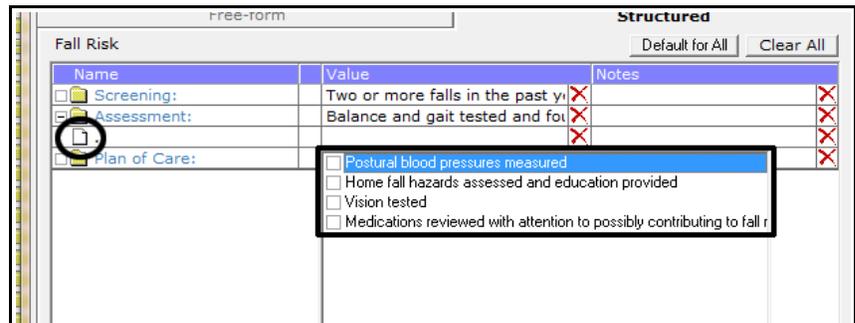


IF the patient has fallen more than once, or one or more times WITH injury, you need to do everything else in this screen.

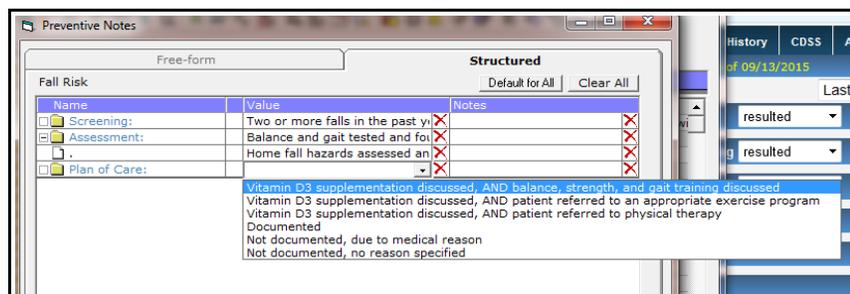
Again, I apologize for how messy this gets – but prior entries couldn't be removed. In the “Assessment” section, you must test gait and balance. This is a requirement of

CMS for this measure. You can put any details in the “Notes” section, but you must state that balance and gait were tested, and found to be normal or abnormal (or could not be tested because the patient is wheelchair-bound, or has some other reason for not testing). Choosing any of the first 3 entries

automatically opens ANOTHER box – again, this is NECESSARY per CMS for this measure. As shown to the right, a new box opens (highlighted by the dark circle) with entries (highlighted by the dark rectangle). According to CMS, you must do at least one of these four things in a patient who meets fall risk assessment criteria (more than two falls, or one fall with injury in the past year). I usually do the second – a simple series of questions about throw rugs, mats in tubs/showers, adequate lighting in hallways/stairwells – whatever you choose – and then suggest changes to the home environment if appropriate. It takes under a minute to do this.



The last necessary element is a “Plan of Care”. CMS has specific requirements here – very much micromanaging this issue. You must DISCUSS vitamin D supplementation (you don't have to advocate



it if you choose not to – but you must discuss it) – AND you must provide advice about balance, strength, and gait training, OR refer to an exercise program, OR refer to PT. Please ignore the last 3 entries. PLEASE choose one of the first three entries – these meet CMS requirements.

The fall risk assessment and plan of care measures are the most time-consuming. Fortunately, many of your Medicare patients have not fallen in the past year – and will be excluded. For those who have fallen (once with injury, or more than one time), you need to spend a few minutes completing this assessment and plan of care. Your MA or nurse can do most of this for you. But it has to be recorded in the PQRS folder to count toward the PQRS benchmark. Remember, PQRS documentation is required on ONCE in 2015. Once you do these screens, you can ignore PQRS for that patient for the rest of 2015.

PQRS penalties apply to all physicians in our group. But it is obviously the PCP's who must jump through all these hoops. I have tried to make this reasonably functional, and fulfill CMS mandates – and I appreciate any constructive advice in how to adapt the current PQRS to our needs.

In 2016, we start with a clean slate, and I hope we can adapt the “Alerts” section to fulfill the current PQRS measures, and any new requirements in 2016. I am told that an upgrade later this year will expand the functionality of the “Alerts” section. We'll see how that works out.

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Updated 9/13/15