

ECW Update

1. **PQRS:** At the recent POD meeting, Dr. Fogle went over how to enter the PQRS data for the diabetic foot exam, fall risk, BMI counseling, and urinary incontinence. The question of whether we need to record the “risk assessment” in order to exclude a patient from the fall risk measure came up. The measure 154 is simply [the number of patients who fell AND had a risk assessment] divided by [the number of patients who fell once with injury or twice regardless of injury in the past year]. It seemed logical to me that if the patient didn't fall, they were excluded from the measure. However, it is not clear if simply NOT falling is enough to exclude the patient – a risk assessment MAY also be necessary. What is the “risk assessment”?

Simply assessing balance and gait is the first part of the assessment, as shown to the right. I simply have the patient stand for 5-10 seconds with his/her eyes closed, and then observe him/her walking to and getting up on the exam table. I am not aware of any set rule for assessing balance and gait.

Name	Value	Notes
Screening:	Two or more falls in the past y	
Assessment:		
Plan of Care:		

Name	Value	Notes
Screening:	Two or more falls in the past y	
Assessment:	Balance and gait tested and fo	
Plan of Care:		

The second part of the assessment is shown to the left – choose one of the four options. I usually just ask a few questions about lighting in hallways/stairs, bannisters/grab bars, throw rugs, and pets – and discuss any risks that come up during the questioning. Even simpler – you can just look at the

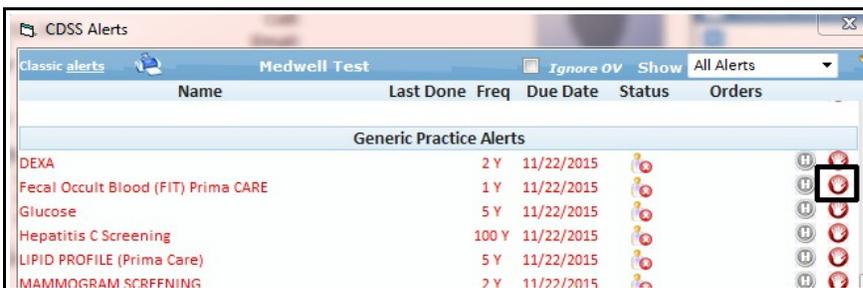
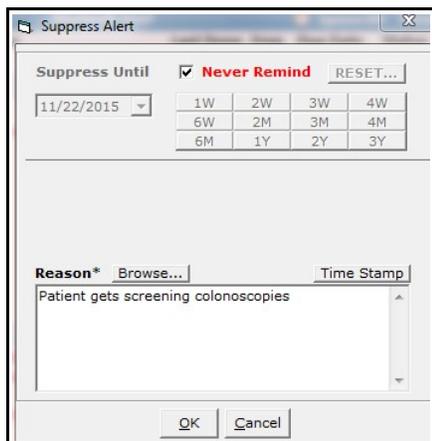
medication list and pick the last option. If I use this option, I usually just put a short statement in the “Notes” section reporting my thoughts.

Again, I am not SURE if you MUST document this for patients who have not fallen – I have not heard back from the experts in PQRS. Obviously, balance and gait problems are usually pretty evident without a formal exam – and you naturally will address this when you see it – but documenting it in the Preventive Medicine PQRS is the only way the data can be mined for CMS. This may be overkill for the 68 year old patient who plays tennis three times a week – but CMS gets what CMS wants – and it only takes 30 seconds and a few extra clicks to complete this measure (I know! We always say “just a few extra clicks” - well, a few extra clicks multiplied by 10-20 things adds up to a lot of extra clicks!). I went through the home hazard questions last week with one gentleman – who looked at me like I had 2 heads and said “You know, I'm not 80 years old!” But PQRS is the metric for “quality medical care”.

2. **Alerts:** MJ and I are still working with Damian (ECW) to try to get ALL of our practice specific alerts running smoothly. The lab and DI options do work well right now – immunization alerts are a problem. The simple thing to remember is that all labs and DI (including colonoscopy – see the last update if you are confused about colonoscopy being filed as a diagnostic image) done at PrimaCARE with AUTOMATICALLY update the alerts – you don't have to do anything!

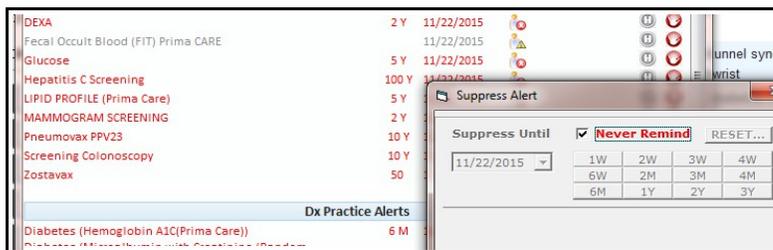
We are not able to suppress the FIT alert if a colonoscopy is done. So, if you want to get rid of this alert for a patient who is getting routine colonoscopies, just suppress it forever.

To do this, open up the CDSS Alerts screen, and choose the picture of the hand as shown to the right.



Then choose “Never Remind” as shown to the left, and put a reason into the “Reason” box. Then click OK.

The screen below shows that the FIT has been suppressed as of 11/22/15 – forever.

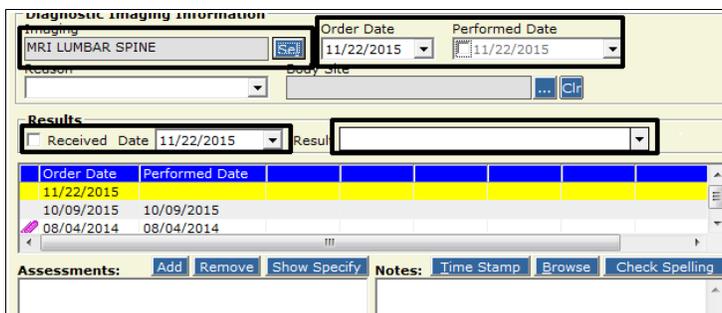


Now, let's say the patient is seen 3 years later, and refuses to do the recommended follow-up colonoscopy. You negotiate with the patient, and he/she agrees to do a FIT test. You can unclick the “Never Remind” button, and order a FIT test. When the result comes back, it will automatically suppress the FIT alert for 1 year. If the patient says he/she will NEVER have another colonoscopy, you can suppress the colonoscopy alert forever.

One minor glitch – we SHOULD be able to set a suppress date in the suppress screen (the “Suppress Until” box). This is not working properly – MJ and I pointed this out to Damian on our most recent conference call with ECW – another problem ECW will hopefully fix in the near future. On that most recent call, the newer version of the alerts screen was shown to us – with a button labeled something like “Import into Note” - clicking on this (in the next ECW upgrade, called SP2) will import an alert into your progress note. With ECW SP2, we will also be able to create structured data alerts – like fall risk, incontinence, DM foot exams, and so on, that will take the place of the rather clunky PQRS folder in the future. We have been told that SP2 should be available in the next few months.

3. Linking outside X-rays to our DI panel:

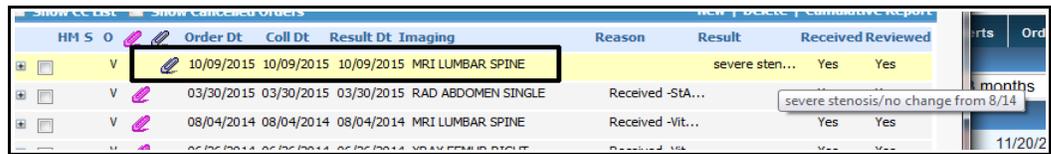
I have found it quite useful to link outside CT scans, echo's, PET scans, MRI's, and whatever else is important to me, to our DI screen. To do this, you first scan the report and put it in “Imaging Documents”. Then create an order in the DI screen by clicking on “New”. Enter in the appropriate information (type of X-ray/lab/procedure), the date performed/received (I use the date of service for all the date entries), and put in a short



comment that will appear next to the DI entry. Then open up the scanned document update screen, and link it to the order. This workflow was discussed in a previous “How To”, but I find this so useful, that I wanted to highlight it again.

I suspect you are quite tired of hearing me say this, but you can find all previous updates and “How To” documents at http://www.drkney.com/html_pages/ecw.htm.

In the screenshot to the right, you see a link to an MRI done at RIH on 10/9/15 – with a little comment



The screenshot shows a table with columns: HM, S, O, Order Dt, Coll Dt, Result Dt, Imaging, Reason, Result, Received, Reviewed. The first row is highlighted in yellow and has a tooltip that says "severe stenosis/no change from 8/14".

HM	S	O	Order Dt	Coll Dt	Result Dt	Imaging	Reason	Result	Received	Reviewed
	V		10/09/2015	10/09/2015	10/09/2015	MRI LUMBAR SPINE		severe sten...	Yes	Yes
	V		03/30/2015	03/30/2015	03/30/2015	RAD ABDOMEN SINGLE	Received -Sta...			
	V		08/04/2014	08/04/2014	08/04/2014	MRI LUMBAR SPINE	Received -Vit...		Yes	Yes

explaining that there is severe spinal stenosis – but unchanged from a prior MRI. It is so much easier to find the outside X-rays this way that I have my office staff do the extra clicks to generate an order for certain high-value data.

4. **Flowsheets:** I am looking forward to being able to use flowsheets to better view cumulative labs. We have not been able to get these to work properly – and addressed this with ECW this week again. We will continue working on this function, and will let you know what the bugs are worked out.

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updated 11/22/15