2016 PQRS

Multiple Chronic Conditions

Measures Group

New Jersey Innovation Institute
An NJIT Corporation

Measures

#47 Care Plan
#110 Preventive Care and Screening: Influenza Immunization
#128 Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan
#130 Documentation of Current Medications in the Medical Record
#131 Pain Assessment and Follow-Up
#134 Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan
#154 Falls: Risk Assessment
#155 Falls: Plan of Care
#238 Use of High-Risk Medications in the Elderly

Reporting Instructions

(1) Identify patients with the following criteria:

- Aged 66 years or older
- Encounter during January 1 - December 31, 2016 with the following:

  One of the following patient encounter codes:
  99487, 99490

  For purposes of the 2016 Multiple Chronic Conditions Measures Group submission of specific diagnosis codes are not required.

(2) Report all applicable measures within the measures group for at least 20 patients.

- The majority of the patients reported must be Medicare Part B Fee-for-service (FFS) patients, including Medicare Secondary and Railroad Medicare.
- For each measure, the measure's clinical performance must be satisfied for at least 1 patient. [Note: An asterisk (*) indicates that the measure's clinical performance is satisfied.]

For additional information or clinical rationale for measures, review the CMS Measure Specification for 2016 PQRS. All measures group Measure Specifications can be found on the NJII Member Portal > Registry > Getting Started section.

Need more information? Connect with NJII PQRS Registry
973-642-4055 • pqrs@njii.com • www.njii.com/pqrs

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Patient Information

First Name | Middle Initial | Last Name | Date of Birth

Visit Date | Medical Record Number | Gender ◯ Male ◯ Female

Medicare FFS Patient ◯ Yes ◯ No

Select Measures Performance

* Recommended clinical performance satisfied
^ Patient is excluded from measure's performance

Select one (1) clinical action for each measure below, where applicable:

#47 Care Plan

Patients (Aged 65 years or older) with a diagnosis of dementia who have an advance care plan or surrogate decision maker documented in the medical record or documentation in the medical record that an advance care plan was discussed but patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan

◯ Tamoxifen or aromatase inhibitor (AI) prescribed*
◯ Not prescribed (Reason documented)^
◯ Not prescribed (No reason documented)
◯ Measure not applicable

#110: Acute Otitis Externa (AOE): Systemic Antimicrobial Therapy – Avoidance of Inappropriate Use

Patients who received an influenza immunization OR who reported previous receipt of an influenza immunization.

For Visit Date 01/01/16-03/31/16: Report if Received 08/01/15-03/31/16

For Visit Date 10/01/16-12/31/16: Report if Received 08/01/16-12/31/16

◯ Administered or previously received*
◯ Not administered (Reason documented)^
◯ Not administered (No reason documented)

Select Measures Performance

#128 Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan

Patients with a documented BMI during the encounter or during the previous six months, AND when the BMI is outside of normal parameters, a follow-up plan is documented during the encounter or during the previous six months of the current encounter

- ◯ BMI calculated as normal*
- ◯ BMI calculated as outside of normal range and follow-up documented*
- ◯ BMI not calculated(Patient not eligible)^
- ◯ BMI calculated as outside of normal range and follow-up NOT documented
- ◯ BMI not calculated (No reason documented)

#130 Documentation of Current Medications in the Medical Record

Eligible professional attests to documenting, updating or reviewing a patient's current medications using all immediate resources available on the date of encounter. This list must include ALL known prescriptions, over-the counters, herbals, and vitamin/mineral/dietary (nutritional) supplements AND must contain the medications' name, dosages, frequency and route of administration

- ◯ Current medications documented*
- ◯ Current medications not documented (Patient not eligible)^
- ◯ Current medications not documented (Reason not given)

#131 Pain Assessment and Follow-Up

Patient visits with a documented pain assessment using a standardized tool(s) AND documentation of a follow-up plan when pain is present

- ◯ Pain assessment documented as negative*
- ◯ Pain present and follow-up plan documented*
- ◯ Pain assessment not performed, or pain assessment positive with no follow-up plan documented; patient not eligible (medical reason documented)^
- ◯ Pain present and no follow-up documented
- ◯ Pain assessment not documented (No reason given)

Select Measures Performance

#134 Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan

Patients with a diagnosis of dementia who have an advance care plan or surrogate decision maker documented in the medical record or documentation in the medical record that an advance care plan was discussed but patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan

- ◯ Screening performed and documented as negative*
- ◯ Screening documented as positive with a follow-up plan*
- ◯ Screening documented as positive with no follow-up plan documented (Reason documented)^
- ◯ Screening documented as positive with no follow-up plan documented (Reason not documented)
- ◯ Screening not performed (Reason documented)^
- ◯ Screening not performed (Reason not documented)

#154 Falls: Risk Assessment

Patients who had a risk assessment for falls completed within 12 months. Patients must also be screened for future fall risk if there is documentation of two or more falls in the past year or any fall with injury in the past year

- ◯ Assessment completed AND patient screened for future fall risk*
- ◯ Assessment not completed (Medical reason documented) AND patient screened for future fall risk^
- ◯ No documentation of falls status^
- ◯ Falls risk assessment not completed (Reason not otherwise specified) AND patient screened for future fall risk

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Select Measures Performance

#155 Falls: Plan of Care

Patients with a plan of care for falls documented within 12 months. All components do not need to be completed during one patient visit, but should be documented.

- ◯ Falls plan of care documented*
- ◯ Plan of care not documented (Medical reason documented)^
- ◯ Plan of care not documented (Reason not documented)
- ◯ Measure not applicable

#238 Use of High-Risk Medications in the Elderly

Percentage of patients who were ordered at least one high-risk medication during the measurement period

NOTE: A lower calculated performance rate for this measure indicates better clinical care or control.

- ◯ One high-risk medication ordered
- ◯ One high-risk medication NOT ordered*