PQRS 2015 – Dementia Measure Group

- #47 Care Plan
- #280 Dementia: Staging of Dementia
- #281 Dementia: Cognitive Assessment
- #282 Dementia: Functional Status Assessment
- #283 Dementia: Neuropsychiatric Symptom Assessment
- #284 Dementia: Management of Neuropsychiatric Symptoms
- #285 Dementia: Screening for Depressive Symptoms
- #286 Dementia: Counseling Regarding Safety Concerns
- #287 Dementia: Counseling Regarding Risks of Driving
- #288 Dementia: Caregiver Education and Support

Patient Sample Criteria

- One of the following diagnosis codes indicating Dementia: 094.1, 290.0, 290.10, 290.11, 290.12, 290.13, 290.20, 290.21, 290.3, 290.40, 290.41, 290.42, 290.43, 290.8, 290.9, 294.10, 294.11, 294.20, 294.21, 294.8, 331.0, 331.11, 331.19, 331.82

- Accompanied by one of the following patient encounter codes: 90791, 90792, 90832, 90834, 90837, 96116, 96118, 96119, 96120, 96150, 96151, 96152, 96154, 97003, 97004, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350

- Visit date between January 1, 2015 - December 31, 2015

- The majority of the patient sample must be Medicare Part B FFS (fee for service) patients.

Reporting Requirement

- All applicable measures much be reported for at least 20 patients.

- Measures groups containing a measure with a 0% performance rate will not be counted as satisfactorily reporting the measures group. The recommended clinical quality action must be performed on at least one patient for each measure within the measures group reported by the eligible professional.

- Measure #47 need only be reported on patients 65 years and older

Patient Information

			☐ Male ☑ Female
First Name	Last Name	Birth Date (mm/dd/yyyy)	Gender
Visit Date (mm/dd/yyyy)	MRN	Physician Name	Medicare ID Number

Measure Performance

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

#47: Care Plan

Patients 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.

Clinical Information		Measure Information
Performed advance care plan or surrogate decision maker documented in the medical record	☐	Advance Care Planning discussed and documented; advance care plan or surrogate decision maker documented in the medical record
patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan	☐	Advance Care Planning discussed and documented in the medical record; patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan
Not Performed (Reason Not Documented)	☐	Advance care planning **not** documented, reason not otherwise specified
Measure Not Applicable	☐	Measure #47 only need be reported on patients 65 years and older.

#280: Dementia: Staging of Dementia

Severity of Dementia was classified as mild, moderate or severe at least once within 12-month period.

Clinical Information		Measure Information
Performed Severity - Mild	☐	Dementia severity classified, mild
Severity - Moderate	☐	Dementia severity classified, moderate
Severity - Severe	☐	Dementia severity classified, severe
Not Performed (Reason Not Documented)	☐	Dementia severity not classified, reason not otherwise specified

#281: Dementia: Cognitive Assessment

Assessment of cognition was performed and the results were reviewed at least once within 12-month period.

Clinical Information		Measure Information
Performed	☐	Cognition assessed and reviewed
Not Performed (Reason Documented) • Medical Reason	☐	Documentation of medical reason(s) for not assessing cognition (eg, patient with very advanced stage dementia, other medical reason)
• Patient Reason	☐	Documentation of patient reason(s) for not assessing cognition
Not Performed (Reason Not Documented)	☐	Cognition **not** assessed and reviewed, reason not otherwise specified

#282: Dementia: Functional Status Assessment

Assessment of functional status was performed and the results were reviewed at least once within a 12-month period.

Clinical Information		Measure Information
Performed	☐	Functional status for dementia assessed and results reviewed
Not Performed (Reason Documented)	☐	Documentation of medical reason(s) for not assessing and reviewing functional status for dementia (eg, patient is severely impaired and caregiver knowledge is limited, other medical reason)
Not Performed (Reason Not Documented)	☐	Functional status for dementia **not** assessed and results **not** reviewed, reason not otherwise specified

#283: Dementia: Neuropsychiatric Symptom Assessment

Assessment of Neuropsychiatric symptoms was performed and results were reviewed at least once in 12-month period.

Clinical Information		Measure Information
Performed	☐	Neuropsychiatric symptoms assessed and results reviewed
Not Performed (Reason Not Documented)	☐	Neuropsychiatric symptoms **not** assessed and results **not** reviewed, reason not otherwise specified

#284: Dementia: Management of Neuropsychiatric Symptoms

Patient received or was recommended to receive an intervention for neuropsychiatric symptoms within 12-month period.

Clinical Information		Measure Information
Performed	☐	One or more neuropsychiatric symptoms, Neuropsychiatric intervention ordered
Not Performed (Reason Documented)	☐	No neuropsychiatric symptoms
Not Performed (Reason Not Documented)	☐	One or more neuropsychiatric symptoms, Neuropsychiatric intervention not ordered, reason not otherwise specified

#285: Dementia: Screening for Depressive Symptoms

Patient was screened for depressive symptoms within 12-month period.

Clinical Information		Measure Information
Performed	☐	Screening for depression performed
Not Performed (Reason Not Documented)	☐	Screening for depression **not** performed, reason not otherwise

#286: Dementia: Counseling Regarding Safety Concerns

Patient or their caregiver(s) were counseled or referred for counseling regarding safety concerns within 12-month period.

Clinical Information		Measure Information
Performed	☐	Safety counseling for dementia provided
Yearly safety counselling provided		
Yearly safety counselling ordered	☐	Safety counseling for dementia ordered
Not Performed (Reason Documented)	☐	Documentation of medical reason(s) for not providing counseling regarding safety concerns
Medical Reason for not providing counseling		
Medical Reason for not ordering counseling	☐	Documentation of medical reason(s) for not ordering safety counseling (eg, patient in palliative care, other medical reason)
Not Performed (Reason Not Documented)	☐	Safety counseling for dementia not provided or ordered, reason not otherwise specified

#287: Dementia: Counseling Regarding Risks of Driving

Patient or their caregiver(s) were counseled regarding the risks of driving and the alternatives to driving at least once within 12-month period.		
Clinical Information		Measure Information
Performed	☐	Yearly counseling provided regarding risks of driving and the alternatives to driving
Not Performed (Reason Documented)	☐	Documentation of medical reason(s) for not counseling regarding the risks of driving (eg, patient is no longer driving, other medical reason)
Not Performed (Reason Not Documented)	☐	Counseling regarding risks of driving and alternatives to driving **not** performed, reason not otherwise specified

#288: Dementia: Caregiver Education and Support

Patient's caregiver(s) were provided with education on Dementia disease management and health behavior changes AND referred to additional resources for support within 12-month period.		
Clinical Information		Measure Information
Performed	☐	Caregiver provided with education and referred to additional resources for support
Not Performed (Reason Documented) Medical reason given	☐	Documentation of medical reason(s) for not providing the caregiver with education on disease management and health behavior changes or referring to additional sources for support (eg, patient does not have a caregiver, other medical reason)
Not Performed (Reason Not Documented)	☐	Caregiver not provided with education and not referred to additional resources for support, reason not otherwise specified