Summary of the MIPS Dashboard

The Rheumatology MIPS Dashboard is a one-stop shop for documenting required data elements for Rheumatology MIPS Measures that were previously difficult to document/track. This is dashboard is simply a GUIDE to make the workflows on these measures easier (FEWER CLICKS). This template is launched from the blue quick links on the Intake template, blue quick links on the SOAP/Dictation template, the Assessment/Plan panel of the SOAP/Dictation template, and the Navigation Panel.

**DISCLAIMER:** To track ALL Quality and Promoting Interoperability measure performance please use NextGen’s HQM module for further analysis.

Intake template:

![Intake Template Image]

SOAP/Dictation template (two places):

![SOAP/Dictation Template Image]
Navigation Panel:

![Navigation Panel Image]

Visual indicators to notify the user of:

- Measure Met
- Treatment Opportunity
- Does Not Meet Denominator
  - IMPORTANT NOTE: If a measure has N/A “Does not meet denominator,” it does not necessarily mean you don’t need to document for it. It simply means that the patient at this time during this encounter does not meet all of the measure denominator criteria. Please make sure to revisit these measures after the patient has been seen by the provider.
- Measure Information Button

Two panels:

- Per Encounter Measures
  - The measures listed under this panel are to be reported at each eligible visit during the performance period.
- Per Performance Period Measures
  - The measures listed under this panel are to be reported a minimum of once per performance period.
Per Encounter Measures

Quality Measure 46: Medication Reconciliation Post Discharge

**Measure Description:** The percentage of patients aged 18 and older discharged from an inpatient facility and seen within 30 days following discharge in the office by the physician, prescribing practitioner, registered nurse, or clinical pharmacist providing on-going care who had a reconciliation of the discharge medications with the current medication list in the outpatient medical record documented.

![Dashboard Guidebook](image)

**Measure Workflow:**

1. Document a facility discharge within 30 days by selecting the *Document Discharge* hyperlink. The *Interim History* pop-up will come up and you will need to enter the *Encounter type* and *D/C date*.
   a. **Please note:** Hospitalization and Hospital are the only two options that will pull the patient into the measure denominator.
2. Then click *Save* and *Close*.

![Dashboard Guidebook](image)

3. Document a medication reconciliation completed by submitting the qualifying CPT Code (1111F) by using the Submit Code button or via the Procedures Module.
   a. **Important Note:** This must be by an MD/DO, midlevel provider or RN.
   b. Once you complete this step, it will populate in the grid below and will change the *Treatment Opportunity Missed* icon to the *Measure Met* icon.
Quality Measure 131: Pain Assessment & Follow Up

**Measure Description:** Percentage of visits of patients aged 18 and older with documentation of a pain assessment using a standardized tool(s) on each visit AND documentation of a follow-up plan when pain is present.

**Measure Workflow:**

1. For patients with a documented pain score greater than zero, complete all fields in the pain management section in the fields below:
   a. Pain scale
   b. Method
   c. Location
   d. Onset
   e. Duration
   f. Quality
   g. Follow-up plan of care
Quality Measure 418: Osteoporosis Management in Women Who Had a Fracture

**Measure Description:** Percentage of women aged 50-85 who suffered a fracture and who either had a bone mineral density test or received a prescription for a drug to treat osteoporosis in the six months after the fracture.

**Measure Workflow:**

1. For female patients 50-85 years old with osteoporosis, for each active fracture document the DXA scan results using the DXA Quick Entry section within 6 months of the fracture occurrence. Document in all the following fields:
   a. Study type (axial/peripheral)
   b. Diagnosis
   c. Interpretation or Result field
   d. Date performed (DXA ever performed)
2. Select the Add button.
   a. Once you complete this step, it will populate in the grid below and will change the Treatment Opportunity Missed icon to the Measure Met icon.

OR

3. Document a qualifying osteoporosis medication in the Medications Module within 6 months of the fracture occurrence
Per Performance Period Measures

Quality Measure 39: Screening for Osteoporosis for Women Age 65-85

**Measure Description:** Female patients aged 65-85 years of age who ever had a central dual-energy x-ray absorptiometry (DXA) to check for osteoporosis.

![Screening for Osteoporosis for Women Age 65-85](image)

**Measure Workflow:**

1. Document the DXA scan results using the DXA Quick Entry section. Document in all the following fields:
   a. Study type (axial/peripheral)
   b. Date performed (DXA ever performed)
   c. Interpretation or Result field
2. Select the Add button.
   a. Once you complete this step, it will populate in the grid below and will change the Treatment Opportunity Missed icon to the Measure Met icon.

![DXA Quick Entry](image)

Quality Measure 109: Osteoarthritis (OA) Function & Pain Assessment

**Measure Description:** Percentage of patient visits for patients aged 21 years and older with a diagnosis of osteoarthritis (OA) with assessment for function and pain.

![OA Function & Pain Assessment](image)
Measure Workflow:

1. For patients with osteoarthritis, document a functional status assessment by selecting Option 1: MDHAQ Detailed hyperlink. Answer questions A-J and the pain score in the MD-HAQ pop-up which will auto-populate the FN score and PN Score.
2. Then click Save & Close.

OR

3. Select Option 2: MDHAQ Brief hyperlink and the brief MD-HAQ Brief pop-up will show. Manually enter the FN score and PN score.
   a. Please note: The PN score can also be documented on the Vital Sign pop-up
4. Then click Save & Close.
Quality Measure 110: Influenza Immunization

**Measure Description:** For patients 6 months and older seen for at least ONE visit during January-March and/or October-December: Order an influenza vaccine OR if the patient has already received a qualifying immunization, document the historical vaccine. If the patient does not receive the vaccine for a patient, system, or medical reason, document an exclusion in the Immunizations module.

![Image of Measure 110: Influenza Immunization]

**Measure Workflow:**

1. Document the administered Influenza vaccine or historically received the vaccine by selecting the “administer or document history Influenza vaccine” blue hyperlink. The *Immunizations* pop-up will come up.
   a. Where to document historical influenza vaccine
2. Once you have completed documenting these, the date when administered/historically received will populate in the Last Flu Vaccination field.

Quality Measure 111: Pneumonia Immunization

Measure Description: For patient’s 65 and older, document the administered pneumococcal vaccine and historically received the vaccination.
Measure Workflow:

1. Document the administered pneumococcal vaccine or historically received the vaccine by selecting the “administer or document history pneumonia vaccine” blue hyperlink. The *Immunizations* pop-up with come up.
   a. Where to document historical pneumococcal vaccine
2. Once you have completed documenting these, the date when administered/historically received will populate in the Last Pneumococcal Vaccination field.

Quality Measure 154: Falls: Risk Assessment

**Measure Description:** Patients aged 65 and older with a history of falls that had a risk assessment for falls completed within 12 months.

**Measure Workflow:**

1. For patients 65 and older with a history of 2+ falls in the last year or a single fall with an injury, document the patient’s fall history by answering the questions if they have fallen in the last year, etc.
2. Document balance, strength, and gait training under the follow-up plan of care section.
3. Selecting the Add button which will then bring up the Vital Signs pop-up.
4. Document the diastolic and systolic blood pressure for Standing, click Save and select Clear for Add.
5. Document the diastolic and systolic blood pressure for Lying, click Save, and Close.
   
a. Once you complete this step, it will populate in the grid below and will change the Treatment Opportunity Missed icon to the Measure Met icon.

Quality Measure 155: Falls: Plan of Care

**IMPORTANT NOTE**: Measure 154 must be completed before documenting for Measure 155.

**Measure Description**: Patients aged 65 and older with a history of falls that had a plan of care for falls documented within 12 months.

**Measure Workflow**:

1. For patients 65 and older with a history of 2+ falls in the last year or a single fall with an injury, document the patient’s fall history and strength, balance, and gait training or a fall plan of care in the section above for Quality Measure 154.
Quality Measure 178: Rheumatoid Arthritis: Functional Status Assessment

**Measure Description:** Patients aged 18 and older with a diagnosis of rheumatoid arthritis (RA) for whom a functional status assessment was performed at least once within 12 months.

**Measure Workflow:**

1. For patients with Rheumatoid Arthritis, document a functional status assessment by selecting Option 1: MDHAQ Detailed hyperlink. Answer questions A-J in the MD-HAQ pop-up which will auto-populate the FN score.
2. Then click **Save & Close**.

OR

3. Select Option 2: MDHAQ Brief hyperlink and the brief MD-HAQ Brief pop-up will show. Manually enter the FN score
4. Then click **Save & Close**.
Quality Measure 226: Tobacco Use: Screening and Cessation Intervention

**Measure Description:** Patients 18 and older who were screened for tobacco use one or more times within 24 months **AND** who received cessation counseling intervention if identified as a tobacco user.

**Measure Workflow:**

1. Select the Tobacco Usage hyperlink.
2. Once the Social History – Tobacco pops up, document if the patient has ever used tobacco by selecting “Yes” or “No/never” and ensure a value populates the Smoking Status AND Tobacco Use Status field. If the patient is a tobacco user, document the tobacco type.

3. Click OK.

4. If the patient is a tobacco user, document tobacco cessation counseling by selecting the tobacco cessation checkbox on the dashboard and the type of cessation given.

5. Select Save & Close.
   a. Once you complete this step, it will populate in the grid below and will change the Treatment Opportunity Missed icon to the Measure Met icon.
Measure Description: For all patients with a diagnosis of Psoriasis, Psoriatic Arthritis or Rheumatoid Arthritis on a Biological Immune Response Modifier with a negative or managed positive TB screening. If TB screening is positive, document the findings AND a Chest x-ray/CT to show evidence of INACTIVE Tuberculosis within ONE year of the start of a Biologic immune Response Modifier medication.

Measure Workflow:

- The grids are just to show if a TB screening was ordered, resulted, and if a Chest X-ray was ordered for a positive TB screening.
- Select the checkbox if you acknowledge that the documentation of:
  - An annual TB screening with a negative finding OR
  - A history of positive TB findings anytime in the patient’s medical history with evidence of INACTIVE TB confirmed through a chest x-ray performed within the past year.

Quality Measure 408: Opioid Therapy Follow Up Evaluation
**Measure Description:** Patients 18 and older prescribed opiates for longer than six weeks’ duration who had a follow-up evaluation conducted at least every three months of Opioid Therapy documented in the medical record.

![Image of the User Interface](image1.png)

**Measure Workflow:**

1. Confirm that the patient has a follow up visit documented in their chart within the initial 3-month period during or after the start of opiate medication therapy. Once you confirm this information, along with the start date of the opiate medication therapy, select the submit code button.

![Image of the User Interface](image2.png)

**Quality Measure 412: Documentation of Signed Opioid Treatment Agreement**

**Measure Description:** Patients 18 and older prescribed opiates for longer than six weeks duration who signed on opioid treatment agreement at least once during Opioid Therapy documented in the medical record.

![Image of the User Interface](image3.png)

**Measure Workflow:**

1. Select the Controlled Substance Treatment Agreement blue hyperlink which will bring up the Controlled Substance Agreement pop-up.
2. Click the “Patient Signed Agreement” checkbox
3. Click **Save & Close**
Once you complete this step, it will populate in the grid below and will change the Treatment Opportunity Missed icon to the Measure Met icon.

**Patient-Specific Education --- NOT REQUIRED!** (CMS has removed this measure from MIPS, but could bring the measure back in future years. TSI recommends continuing to complete this measure as part of your workflow “just in case”.)

**Measure Description:** A clinician must use clinically relevant information from CEHRT to identify patient-specific educational resources and provide access to those materials to at least one unique patient seen by the MIPS EC. If the patient has not received patient education on the current office visit, there will be the Treatment Opportunity Missed icon.

**Measure Workflow:**

1. Select the “Patient Education” blue hyperlink.
2. Select a patient education document from the Recommended Search Criteria section. Select the **Send to the Patient Portal** button.
   a. If the “Send to Patient Portal” button is grayed out, this means the patient is not enrolled in patient portal.
   b. This will populate the grid and will change the Treatment Opportunity Missed icon to the Measure Met icon.
Important Last Steps!

1. Make sure to go back into the MIPS Dashboard – RHE template at the end of the provider’s workflow as there may be a measure that became a Treatment Opportunity.
   a. Refer back to measures: 46, 109, 337, and 418
2. Once you finished documenting on the MIPS Dashboard – RHE template, please make sure to click the Save & Close button at the bottom.