

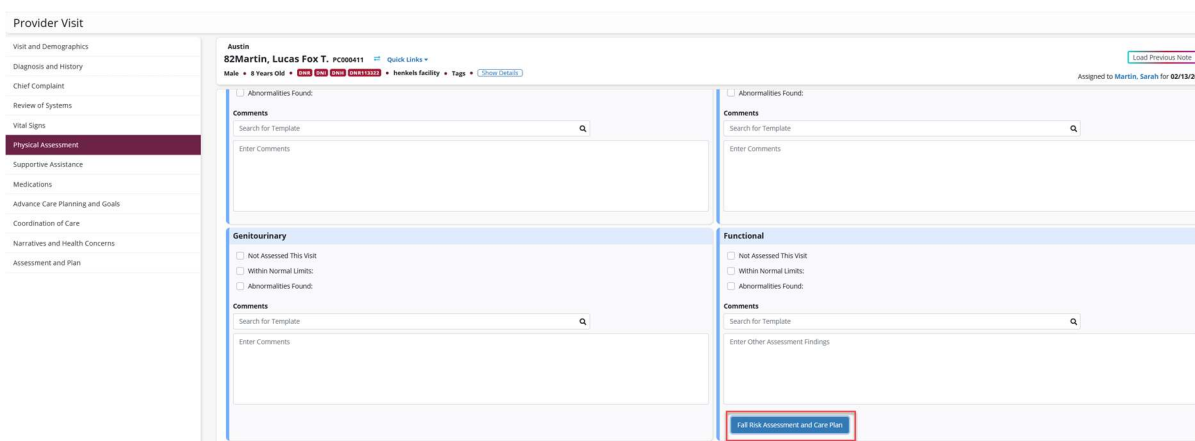
CQM 155 Falls Plan of Care

Documentation Step-by-Step

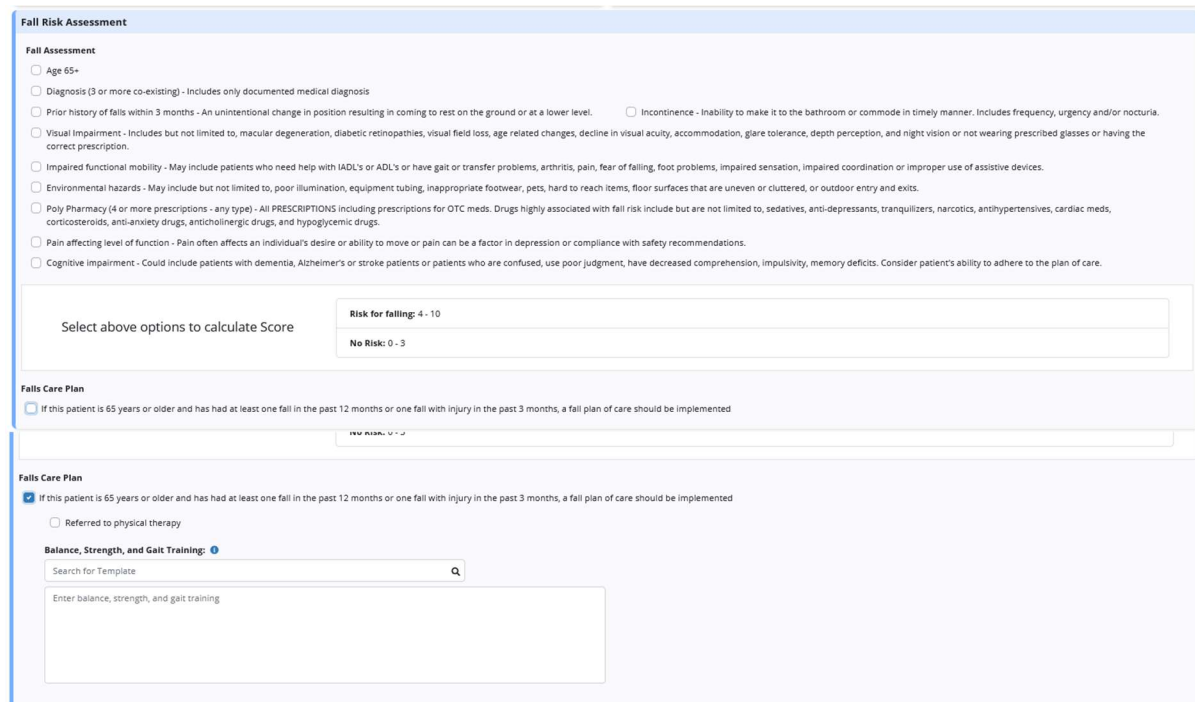
Users must document using a billable visit for a patient with a CPT code that qualifies for the measure (this is most routine CPT codes).

The Falls Risk Assessment and Plan of Care are located in the functional assessment section of a clinical visit.

To open and document the Fall Risk Assessment and Care Plan select the Fall Risk Assessment and Care Plan button within the Functional tile of the Physical Assessment.



The screenshot shows the 'Provider Visit' interface. On the left is a sidebar with a menu including 'Visit and Demographics', 'Diagnosis and History', 'Chief Complaint', 'Review of Systems', 'Vital Signs', 'Physical Assessment' (highlighted), 'Supportive Assistance', 'Medications', 'Advance Care Planning and Goals', 'Coordination of Care', 'Narratives and Health Concerns', and 'Assessment and Plan'. The main area displays patient information for 'Austin, Lucas Fox T.' and a list of tabs: 'Genitourinary' and 'Functional'. The 'Functional' tab is active, showing a 'Comments' section with a search bar and a text area. At the bottom of the 'Functional' tab, a button labeled 'Fall Risk Assessment and Care Plan' is highlighted with a red box.



The screenshot shows the 'Fall Risk Assessment' form. It includes a 'Fall Assessment' section with checkboxes for various risk factors such as 'Age 65+', 'Diagnosis (3 or more co-existing)', 'Prior history of falls within 3 months', 'Visual Impairment', 'Impaired functional mobility', 'Environmental hazards', 'Poly Pharmacy', 'Pain affecting level of function', and 'Cognitive impairment'. Below this is a 'Select above options to calculate Score' section with two input fields: 'Risk for falling: 4 - 10' and 'No Risk: 0 - 3'. The 'Falls Care Plan' section includes a checkbox for 'If this patient is 65 years or older and has had at least one fall in the past 12 months or one fall with injury in the past 3 months, a fall plan of care should be implemented'. Below this is a 'Falls Care Plan' section with a checkbox for 'Referred to physical therapy' and a 'Balance, Strength, and Gait Training' section with a search bar and a text area.

Workflow: When you complete a visit, the CPT code screen appears with the Clinical Quality Measures tile. From this tile select the appropriate CPT code per the description and category.

Performance Met (0518F) - Falls plan of care documented.

Denominator Exception (0518F with 1P) - Patient not ambulatory, bed-ridden, immobile, confined to chair, wheelchair bound, dependent on helper pushing wheelchair, independent in wheelchair or minimal help in wheelchair.

Performance Not Met (0518F with 8P) - Falls plan of care not documented, reason not otherwise specified.

Provider Visit

Clinical Quality Measures

Advance Care Planning

- ☐ 1123F - Measure Met: Advance care planning discussed and documented; advance care plan or surrogate decision-maker documented in the medical record
- ☐ 1123F(8P) - Performance Not Met: advance care planning not documented, reason not otherwise specified
- ☒ 1124F - Measure Met: 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

Falls Plan of Care

- ☐ 0518F - Measure Met: Fall plan of care documented
- ☐ 0518F(1P) - Measure Exception: Patient not ambulatory, bed ridden, immobile, confined to chair, wheelchair bound, dependent on helper pushing wheelchair, independent in wheelchair or minimal help in wheelchair
- ☒ 0518F(8P) - Measure Not Met: Fall plan of care not documented, reason not otherwise specified

Elder Maltreatment Screening

- ☐ G8535 - Measure Exception: Elder maltreatment screening not documented; documentation that patient is not eligible for the elder maltreatment screen at the time of the encounter
- ☐ G8536 - Measure Not Met: No documentation of an elder maltreatment screening, reason not given
- ☐ G8733 - Measure Met: Elder maltreatment screening documented as positive and a follow-up plan is documented
- ☐ G8734 - Measure Met: Elder maltreatment screening documented as negative, follow-up is not required
- ☐ G8735 - Measure Not Met: Elder maltreatment screening documented as positive, follow-up plan not documented and reason not given
- ☒ G8941 - Measure Exception: Elder maltreatment screening documented as positive, follow-up plan not documented, documentation the patient is not eligible for follow-up plan at the time of the encounter

Dementia: Functional Status Assessment

- ☐ G9916 - Measure met: Functional status performed once in the last 12 months
- ☐ G9917 - Measure met: Documentation of advanced stage dementia and caregiver knowledge is limited Measure Not Met
- ☒ G9918 - Performance not met - Functional status not performed, reason not otherwise specified

Screening for Social Drivers of Health

- ☐ M1207 - Measure met: Patient is screened for food insecurity, housing instability, transportation needs, utility difficulties, and interpersonal safety
- ☐ M1208 - Performance not met - Patient is not screened for food insecurity, housing instability, transportation needs, utility difficulties, and interpersonal safety
- ☒ M1237 - Measure met: Patient reason for not screening for food insecurity, housing instability, transportation needs, utility difficulties, and interpersonal safety (e.g., patient declined or other patient reasons)