Stage 2 – Measures and Issues

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What is our purpose?

- Examine 17 core and 6 menu measures
- Determine implications for clinic –
  - Workflow
  - Portals, interfaces, standard languages
  - Cost, time, provider workload
  - What does it mean for quality reporting?
  - Where does this fit in the EHR timeline?
  - How does this affect PCMH documentation?

Stage 2 – Core Measures

Must meet all measures

- ❑ **Orders & Charting**
- ❑ **Patient Engagement**
- ❑ **Quality Improvement**
- ❑ **Interoperability**
- ❑ **Security**

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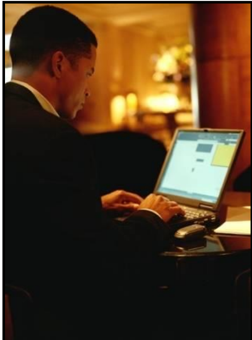
Orders and Charting
Orders and e-prescriptions



1. Use EHR to write orders
   60% of medications,
   30% of laboratory, and
   30% of radiology imaging
   Electronic transmittal is <u>not</u> required
2. More than 50% of permissible prescriptions
   Checked against an internal formulary, and
   Sent electronically

Orders and Charting
Demographics, vitals, smoking

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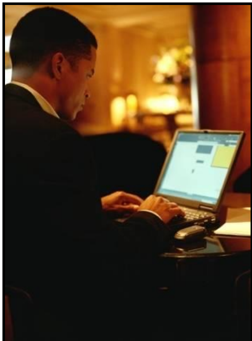

3. More than 80% of unique patients have data entered; need not be updated on every visit (**Language, race, ethnicity, sex, DOB)**
4. More than 80% have ht, wt, bp (>3 yrs) recorded. Do one, do all. EHR must calculate BMI and plot growth chart.
5. More than 80% of patients age 13 and up have smoking status recorded. Does not need to be updated on every visit.
(Must use SNOMED CT categories.)

Orders and Charting
Reconcile Medications

14. Reconcile medication lists for more than 50% of patients received in transfer of care from another setting or provider
    - New patient, first encounter
    - Existing patients where summary of care record is received (any form, any souce)

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Quality Improvement
Patient condition list

11. Generate at least one report of patients with a specific condition
    - For use in quality improvement, outreach, reduction of disparities
    - Must be done within the reporting period (last year’s does not count)

Quality Improvement
Clinical Decision Support

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6. Implement 5 clinical decision support interventions
   - Related to 4 or more quality measures
   - Based on problem list, meds, allergies, vitals, lab results, demographics
   - Also enable drug-drug/drug-allergy check for the entire period (does not count as one of the 5)

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Quality Improvement
Clinical Quality Measures

- Must report 9 measures from at least 3 of the 6 domains:

Patient & family engagement	Population & Public Health
Patient Safety	Efficient use of resources
Care Coordination	Clinical process/effectiveness

  - See recommended core pediatric CQMs
  - See recommended core adult med CQMs
- How will these align with other QI reporting?

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Patient Engagement

Patient Portal – view, download, or transmit

7. More than 50% of patients have health information available within 4 business days **(problem list, procedures, test results, meds, allergies, smoking status, demographics, vitals – including BMI and growth chart – care plan goals and instructions, care team members)**

- Provider may decide to withhold info
- Privacy issues for minors (eg, 13-18)
- More than 5% view, dowload, or send to a third party

Patient Engagement
Patient messaging

17. More than 5% of patients (or their authorized representatives) send a secure message to their provider
    - Using messaging function of EHR (email, patient portal, other)
    - Provider need not personally respond
    - Provider/staff may decide follow-up phone call or office visit is more appropriate as an answer

Patient Engagement
Reminders for preventative or follow-up care

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12. More than 10% of active patients (2 visits in 24 months) are sent a reminder for preventative or follow-up care

- Per patient preference (phone, mail, secure messaging, etc) but not by time of day – known, reasonable requests
- Must be for care that patient is not already scheduled to receive; reminders for referrals and events do count
- Patient may decline to state preference or may refuse reminders

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Patient Engagement
Patient Education Resources

13. Provided to more than 10% of patients with office visits
    - EHR evaluates problem list, meds, lab results and suggests resources
    - Resources do not have to be stored within or generated by EHR
    - Provider makes final decision and provides paper, document on patient portal, link, etc.

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Patient Engagement
Clinical Summaries

8. More than 50% of office visits – given to patient or patient-authorized representative within 1 business day – full visit summary, not just 4 items

- Any separate, billable encounter, including tele-health

Patient name
Provider name/office
Date & location
Reason for visit
Current problem list
Current medications
Current allergies
Demographics
Smoking status
Vitals taken (or prior)

Procedures during visit
Immunizations during visit
Lab test results
Labs or tests pending
Future scheduled tests
Clinical instructions
Future appointments
Care plan (goals & instructions)
Recommended decision aids

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Interoperability
Summary of Care record

15. Provide a summary of care record for transitions to another provider or setting for more than 50% of transitions
    - More than 10% are sent electronically from the EHR or through an HIE
    - Conduct one electronic test with a provider using a different EHR or a CMS test EHR
    - CMS will provide more details (remember the CCD test?)

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Interoperability
Laboratory tests

10. More than 55% of lab rest results (numerical or +/- values) recorded as structured data.

- No explicit link between order and result is required.
- LOINC is preferred language
- Microbiology reports are still scanned from lab results

Interoperability
Immunization reporting

16. Submit immunization data electronically (HL7 2.5.1) to registry (CAIR) for entire reporting period.
    - CAIR plans to open gateway in August. See http://cairweb.org/data-exchange-tech-support/
    - Expect CAIRWeb terminal reporting to be discontinued in 2013
    - Mapping and matching problems will occur

Security Risk Analysis
No checklist; once per year/period

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9. Conduct (document) a security risk analysis; address encryption/security of data stored in EHR
   - Best Office of Civil Rights documentation is at http://www.hhs.gov/ocr/privacy/hipaa/administrative/securityrule/smallprovider.pdf
   - And more broadly at http://www.hhs.gov/ocr/privacy/hipaa/administrative/securityrule/rafinalguidancepdf.pdf
   - A CA HHS tool is at http://www.ohii.ca.gov/calohi/ click on Security Tool at the bottom of the page
   - Or this paper tool from CalOHI http://www.ohi.ca.gov/calohi/Portals/0/Documents/PrivacySecurity/HIPAA/Rules/Security/HIPAAComplianceReviewSecurityool.pdf

Stage 2 – Menu Set Measures

Must meet three (3) from the five measures

- Enhanced charting
- Disease reporting

Enhanced Charting
Electronic progress notes

2. More than 30% of unique patients with at least one office visit in the reporting period have at least one electronic note entered in the EHR
   - Note must be text searchable; may contain drawings and other content
   - Non-searchable notes do not qualify

Enhanced Charting
Images accessible from EHR

3. More than 10% of all tests whose results are images ordered by the provider are accessible through the EHR
   - Image and accompanying information
   - May be stored in the EHR or available through a link to another location

Enhanced Charting
Family history

4. More than 20% of patients have a structured entry for one or more first-degree relatives
   - Parents, offspring, siblings
   - "Unknown" is an acceptable entry

Disease Reporting
Syndromic Surveillance

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1. Submit syndromic health surveillance data electronically to a public health agency for the entire reporting period.

- LA County DPH not capable; see http://publichealth.lacounty.gov/acd/ADSS.htm
- DPH auto reply at meaningfuluse@ph.lacounty.gov
  LACDPH is currently at capacity and unable to update existing syndromic surveillance data interfaces or establish new interfaces with eligible hospitals and providers to receive syndromic surveillance data electronically. Eligible hospitals and providers may test their messages through the Centers for Disease Control and Prevention's automated testing tool (http://www.cdc.gov/phin/resources/certification/MQFtool-overview.html).

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Disease Reporting
Disease registries

5. Ongoing submission of cancer case information to a public health agency cancer registry for the entire period.
   - Caveats, exclusions, and registry specifics apply

6. Ongoing submission of specific case information to a specialized (non-cancer) registry for the entire period.
   - Caveats, exclusions, and registry specifics apply

A final word about Audit Prep

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Audit documentation
Keep records for 6 years

- See federal advice at http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/EHR_SupportingDocumentation_Audits.pdf
- EHR reports, screenshots, emails, lists – all dated during the reporting period and clearly showing period dates, provider name, etc.
- Letter audit, asking for documentation. Other steps may follow. CMS may recoup funds.
- State has not issued guidelines yet.