Is an EHR the Answer to Quality Reporting?

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HTS is a department of Mountain-Pacific Quality Health Foundation
Agenda

- Who is HTS
- Payment Reform
- HIT Acronyms
- HIT Standards
- Certified EHR Technology
- Quality Reporting Programs
- Reporting Quality Measures using CEHRT
Learning Objectives

Attendees will learn the following:

- Why quality reporting is essential to payment reform
- What is Certified EHR Technology
- How to determine what quality measures the EHR is certified to report
- What is needed to report Clinical Quality Measures electronically
- Is an EHR the answer to Quality Reporting
What is a Regional Extension Center?

- We assist health care facilities with utilizing Health Information Technology (HIT) to improve health care quality, efficiency and outcomes.

As we wrap up with the REC contract

- HTS has assisted over 1300 providers and 49 Critical Access Hospitals to reach Meaningful Use
- HTS ranks 11th in the nation in assisting CAHs reach MU
- HTS ranks 15th nationally in assisting Priority Primary Care Providers reach MU
Historically, Medicare’s fee–for–service (FFS) payment systems rewarded providers for the volume of services they provided to the program’s beneficiaries.

- The more services a provider delivered, the higher its Medicare revenues.
- Medicare made the same payments to high-quality providers as it did to lower quality providers.
Payment Reform and Quality Reporting

- When bills are paid under FFS by a third party, patients (along with physicians) have no incentive to consider the cost of treatment. In this model, physicians can choose to order more tests and perform more procedures.

- With FFS health care, there is no penalty nor incentive for valuing health care outcomes over service quantity.
2013 US Health Care Spending

- $2.9 trillion on health care in 2013
- Equivalent to about $9,255 per person
- Health care spending as a share of the economy was 17.4 percent
- Hospital care ($936.9 billion)
2013 US Health Care Spending

- Physicians and clinical services ($586.7 billion)
- Prescription drugs ($271.1 billion)
- The CMS actuary's most recent projections predict that health spending will almost double to $5.2 trillion in 2023, when it will account for 19.3 percent of the economy.
What does the future hold?

- **More Medicare Beneficiaries** – the over-65 population will triple between 1980 and 2030, with the first baby boomers turning 65 in 2011.

- **Fewer taxpayers** – the number of taxpaying workers per Medicare beneficiary has declined from 4.6 in the early years of the program to 3.1 today; by 2030, the Medicare trustees project this number will be 2.3.
“You cannot manage what you cannot measure”
Peter Drucker
Changing direction

- **Quality health care** is a high priority for the President, the Department of Health and Human Services (HHS), and the Centers for Medicare & Medicaid Services (CMS).
Changing direction

- CMS implements **quality initiatives** to assure quality health care for Medicare Beneficiaries through accountability and public disclosure.

- CMS uses **quality measures** in its various quality initiatives that include quality improvement, pay for reporting, and public reporting.
The term “value based health care” encompasses a range of initiatives aimed at the combined goals of driving down costs while improving patient outcomes.

Value based health care is about rewarding health care quality rather than volume—quality-focused payments.

For patients, value based health care signifies safe, appropriate, and effective care at reasonable cost.
For physicians and hospitals, it requires using evidence-based medicine and proven treatments and techniques.

The focus may also put patients at the center, taking their wishes and preferences into account.

“Quality in a service or product is not what you put into it. It is what the client or customer gets out of it.”
~Peter Drucker
Value Based Health Care

- Value based health care removes the incentive for providers to earn more money by performing more services. Instead, providers are rewarded for achieving certain quality and cost outcomes—and can be penalized for failing to meet certain quality and cost benchmarks.
“Quality is never an accident; it is always the result of high intention, sincere effort, intelligent direction and skillful execution; it represents the wise choice of many alternatives.” ~William A. Foster
HIT Acronyms aka Alphabet Soup!

- HIT – Health Information Technology
- EHR – Electronic Health Record
- MU – Meaningful Use
- PQRS – Physician Quality Reporting System
- PCMH – Patient Centered Medical Home
- CQM – Clinical Quality Measures
HIT Acronyms aka Alphabet Soup!

- NQF – National Quality Forum
- NQS – National Quality Strategy
- HIE – Health Information Exchange
- CDS – Clinical Decision Support
- SRA – Security Risk Assessment
- QRDA – Quality Reporting Document Architecture
The specifications for the electronic submission of CQMs in a Quality Reporting Document Architecture (QRDA) format necessitate stringent data capture to meet the output requirements.

- LOINC
- SNOMED
- SNOMED CT
- ICD9/ICD10
- CPT
- PHIN VADS
- Rx Norm
LOINC

- Logical Observation Identifiers Names and Codes
  - Universal standard for identifying medical laboratory observations
  - Was created and is maintained by the Regenstrief Institute, a US non-profit medical research organization
  - Was created in response to the demand for an electronic database for clinical care and management
  - Is publicly available at no cost
SNOMED

- **Systematized Nomenclature of Medicine**
  - Is a systematic, computer-processable collection of medical terms
  - Covers anatomy, diseases, findings, procedures, microorganisms, substances, etc
  - Allows a consistent way to index, store, retrieve, and aggregate medical data across specialties and sites of care
  - Was started in the US by the College of American Pathologists in 1973

- SNOMED-CT is a restructured form useful for cross mapping and use in EHRs
The International Classification of Diseases

- The international "standard diagnostic tool for epidemiology, health management and clinical purposes"

- Designed as a health care classification system, providing a system of diagnostic codes for classifying diseases, including nuanced classifications of a wide variety of signs, symptoms, abnormal findings, complaints, social circumstances, and external causes of injury or disease
ICD9/ICD10

The International Classification of Diseases

- Designed to map health conditions to corresponding generic categories together with specific variations, assigning for these a designated code

- ICD9 has been used in the US for Medicare and Medicaid claims since 1979

- ICD10 goes into effect for Medicare and Medicaid claims starting 10/1/15
CPT

The **Current Procedural Terminology** code set

- Medical code set that is maintained and copyright protected by the American Medical Association (AMA)

- Describes medical, surgical and diagnostic services

- Designed to communicate uniform information about medical services and procedures
CPT

- New editions are released each October – current version is the CPT 2015

- CPT coding is similar to ICD9 and ICD10 coding, except that it identifies the services rendered rather than the diagnosis on the claim

- ICD code sets also contain procedure codes but these are only used in the inpatient setting
Public Health Information Network (PHIN) Vocabulary Access and Distribution System (VADS)

- Provides standard vocabularies to CDC and its Public Health partners in one place

- Web-based enterprise vocabulary system for accessing, searching and distributing vocabularies used in public health and clinical care practice
PHIN VADS

- Promotes the use of standards-based vocabulary to support the exchange of consistent information among Public Health partners
- There are 35 code systems, 1,200 value sets and over 2 million concepts in PHIN VADS based on the code system/domain recommendations and value set recommendations from Health Information Technology Standards Panel
- The main purpose of PHIN VADS is to distribute the value sets associated with HL7 message implementation guides
Rx Norm

A normalized naming system for generic and branded drugs

- A tool for supporting semantic interoperability between drug terminologies and pharmacy knowledge base systems

- RxNorm provides normalized names and unique identifiers for medicines and drugs to allow computer systems to communicate drug-related information efficiently and unambiguously
Rx Norm

- RxNorm contains the names of prescription and many over-the-counter drugs available in the United States. RxNorm includes generic and branded:
  - Clinical drugs – pharmaceutical products given to (or taken by) a patient with therapeutic or diagnostic intent
  - Drug packs – packs that contain multiple drugs, or drugs designed to be administered in a specified sequence
  - Radiopharmaceuticals, bulk powders, contrast media, food, dietary supplements, and medical devices, such as bandages and crutches, are all out of scope for RxNorm
The Office of the National Coordinator for Health Information Technology (ONC) Certification Program provides a defined process to ensure that Electronic Health Record (EHR) technologies meet the adopted standards and certification criteria to help providers and hospitals achieve Meaningful Use (MU) objectives and measures established by the Centers for Medicare and Medicaid Services (CMS).

- Eligible professionals and eligible hospitals who seek to qualify for incentive payments under the Medicare and Medicaid EHR Incentive Programs are required to use certified EHR technology.
Certified HIT Product List (CHPL)

Comprehensive List of Certified Health Information Technology

Start by searching the list of certified products:

Product Name

View all products

http://oncchpl.force.com/ehrcert
Goals of using CEHRT

- Improve Patient Care
- Improve Care Coordination
- Increase Patient Participation
- Improve Diagnostic Patient Outcomes
- Improve Efficiencies and Cost Savings
- Standardize data
CEHRT and Quality Measures

Clinical Quality Measures

- CMS2  PREVENTIVE CARE AND SCREENING: SCREENING FOR CLINICAL DEPRESSION AND FOLLOW-UP PLAN
- CMS22  PREVENTIVE CARE AND SCREENING: SCREENING FOR HIGH BLOOD PRESSURE AND FOLLOW-UP DOCUMENTED
- CMS50  CLOSING THE REFERRAL LOOP: RECEIPT OF SPECIALIST REPORT
- CMS52  HIV/AIDS: PNEUMOCYSTIS JIROVECI PNEUMONIA (PCP) PROPHYLAXIS
- CMS56  FUNCTIONAL STATUS ASSESSMENT FOR HIP REPLACEMENT
- CMS61  PREVENTIVE CARE AND SCREENING: CHOLESTEROL – FASTING LOW DENSITY LIPOPROTEIN (LDL-C) TEST PERFORMED
- CMS62  HIV/AIDS: MEDICAL VISIT
- CMS64  PREVENTIVE CARE AND SCREENING: RISK-STRATIFIED CHOLESTEROL – FASTING LOW DENSITY LIPOPROTEIN (LDL-C)
- CMS65  HYPERTENSION: IMPROVEMENT IN BLOOD PRESSURE
- CMS66  FUNCTIONAL STATUS ASSESSMENT FOR KNEE REPLACEMENT
- CMS68  DOCUMENTATION OF CURRENT MEDICATIONS IN THE MEDICAL RECORD
- CMS69  PREVENTIVE CARE AND SCREENING: BODY MASS INDEX (BMI) SCREENING AND FOLLOW-UP
- CMS74  PRIMARY CARIES PREVENTION INTERVENTION AS OFFERED BY PRIMARY CARE PROVIDERS, INCLUDING DENTISTS
Quality Initiatives and Reporting Programs

- Hospital Quality Initiative
  - Hospital Inpatient Quality Reporting Program (HIQR/IQR – mandated in 2003)
  - Hospital Outpatient Quality Reporting Program (HOQR/OQR – mandated in 2006)
  - Hospital Value Based Payment Program (HVBP – mandated in 2011)

- Inpatient Psychiatric Facility Quality Reporting Program (IPF – mandated in 2011)
More Quality Programs

- Home Health Quality Initiative
- Ambulatory Surgery Center Quality Reporting Program
- Inpatient Rehabilitation Quality Programs
- Nursing Home Quality Assurance and Performance Improvement
In order to report CQMs from an electronic health record (EHR), electronic specifications (e−specifications) must be developed for each CQM.

The e−specifications include the data elements, logic and definitions for that measure in an Health Level Seven (HL7) standard known as the Health Quality Measures Format (HQMF) which represents a clinical quality measure as an electronic Extensible Markup Language (XML) document that can be captured or stored in the EHR so that the data can be sent or shared electronically.
Quality Reporting Document Architecture (QRDA)

- Informative Document

The Health Level Seven International (HL7) QRDA is a standard document format for the exchange of electronic clinical quality measure (eCQM) data. QRDA reports contain data extracted from electronic health records (EHRs) and other information technology systems. QRDA reports are used for the exchange of eCQM data between systems for a variety of quality measurement and reporting initiatives, such as the Centers for Medicare & Medicaid Services (CMS) EHR Incentive Program: Meaningful Use Stage 2 (MU2).
The Office of the National Coordinator for Health Information Technology (ONC) adopted QRDA as the standard to support both QRDA Category I (individual patient) and QRDA Category III (aggregate) data submission approaches for MU2 through final rulemaking in September 2012. CMS and ONC subsequently released an interim final rule in December 2012 that replaced the QRDA Category III standard adopted in the September 2012 final rule with an updated version of the standard.
## CQM Crosswalks

<table>
<thead>
<tr>
<th>CMS eMeasure ID &amp; CQM Number</th>
<th>CQM Title &amp; Description</th>
<th>Measure Steward &amp; Contact Information</th>
<th>Other Quality Measure Programs that use the Same CQM</th>
<th>Domain</th>
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| CMS165v1                    | Controlling High Blood Pressure  
Percentage of patients 18-85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90mmHg) during the measurement period. | National Committee for Quality Assurance (NCQA): www.ncqa.org | ▪ EHR PQRS  
▪ ACO  
▪ Group Reporting  
▪ PQRS  
▪ UDS | Clinical Process/Effectiveness |
| NQF 0018                    |                         |                                       |                                                   |        |
|                             |                         |                                       |                                                   |        |
| NEW: CMS156v1               | Use of High-Risk Medications in the Elderly  
Percentage of patients 66 years of age and older who were ordered high-risk medications. Two rates are reported. | NCQA: www.ncqa.org | PQRS | Patient Safety |
| NQF 0022                    |                         |                                       |                                                   |        |
|                             |                         |                                       |                                                   |        |
Where can quality data be used?

- Corporate or National level (Population Health)
- Unit or Organization level (Community Health)
- Patient level data

“Without data.. You’re just another person with an opinion”

Joseph Juran
Questions

Thank You!
HTS offers services to support the following:

- EHR Selection and Implementation assistance
- Meaningful Use EHR Program assistance
- PQRS and other quality reporting assistance
- HIPAA Security Risk Assessments and support
- PCMH Certification assistance
- HIT utilization for Healthcare quality improvement projects
- HIT Project Management
- HIT Misc Consulting

If you are interested in any of these services, please contact Deb Anderson or your HTS Account Manager
Contact information

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