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Learning and Action Network (LAN): Quality Measurement and Reporting Part II

Presented by Paul Kleeberg, MD, FAAFP, FHIMSS, CMIO and Phil Deering, REACH Regional Coordinator
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Jerri Hiniker: Welcome everyone to our second webinar of Quality Measurement and Report Part II of Learning and Action Network. Our presenters today will be Dr. Paul Kleeberg and Phil Deering. Our agenda for today is:

→ To review the stage I quality core measures for Meaningful Use.
→ What does EHR certification mean related to these quality measures?
→ Why these measures matter
→ Discussion: How are you doing in each of your facilities?

So thank you everyone for attending. With that I’ll turn the floor over to Dr. Kleeberg.

Paul Kleeberg: Thank you Jerri, good afternoon everyone. Today we’re going to be talking about the quality measures. These are the ones’ that are required to be reported as part of Meaningful Use. These are for Meaningful Use stage I and actually, the quality measures that we’ll report on through 2013.

They are all related to healthcare quality aims such as effective and efficient patient care and they’re trying to look at processes care and make sure the care is actually, the quality is there and the care is improving. So, they’ve brought them mainly from PQRI and NQF endorsed measures; however, some are not in complete harmony with those measures.

Some measures actually have slightly different numerators or denominators, which they’re planning on fixing, going forward. The way it stands that’s where they come from and as you probably know they are divided into two measure groups. The core set of 3 measures which one must do or if unable to, select from the alternates and 3 additional measures must be selected from among 38 others. So you have to report on the total of six measures for Meaningful Use.

Now, for 2012, the reporting method is slightly different. Professionals can do the way they did in 2011. They can go online and report the same way they did in 2011, but they’re also trying this pilot through PQRS. If you’re not sure how to report your numbers through PQRS or are reporting numbers for PQRS, you can do it electronically. You would actually fulfill your criteria for Meaningful Use and if you’re reporting to the state, which we aren’t ready to yet, but the plan is that it will be available by the end of this year, so you would be reporting directly to the state if you were just choosing Medicaid.

These measures all have electronic specifications for reporting, so you don’t need to do a chart review of any of the data, though sometimes you may want to prepare the data from your EHR with your data, just to reflect what you’re doing. You’re reporting on
patients who are in the EHR not patients on paper and you’re reporting on any patient regardless of whether they’re Medicare or Medicaid.

Now these are the six measures that are on the core and alternate core, so most everyone will report on the first three…

- Blood pressure measurement
- Tobacco use assessment, and
- Adult weight screening

Let’s say you’re a pediatrician and the first and third measures don’t fit into your practice. You would have a zero in your denominator. For each zero in the denominator that you have in the core measures, you need to choose an alternate core. So, for example, if two were zeroed out in the core, then you would report a two from the alternate core.

You could potentially, have zero denominators of all these measures and that would not eliminate your ability to achieving equal use. For this stage of Meaningful Use is payment for reporting and not payment based on improvement.

1. The first one is looking at hypertension. If you have a diagnosis of hypertension on the patient’s chart and they’re over 18 years of age, then you must have a measure of systolic and diastolic blood pressures on the chart during measurement periods. If you don’t you’ll get a zero in that numerator and one in the denominator.

The tobacco one is actually broken into two parts. Again, this is for a patient over the age of 18 and if you’ve seen them in your office twice where you’ve done a physical or preventative exam, then they would count in your denominator and you need to find out whether or not they’ve used tobacco in the last two years, and saying so will fulfill this first half of this measures.

The second half of this measure is if those same people said yes they have used tobacco in the past two years, you need to say whether they’ve received tobacco cessation counseling or some method of tobacco cessation being a medication or something else that assisted them in quitting smoking in the past two years. That measurement would need to be accounted for during the measurement period.

You may not have needed to have done the counseling, but you need to report that the counseling was done in the past two years when you reported during the measurement period.

The last of the core one, also has two measures. It’s measuring overweight and under weight. When you do a BMI for a person over the age of 65, as this example is, and they are in the normal range that patient would count in your numerator. However, if they fell outside that normal range then you can see that’s defined that between 22kgm and 30kgm, then you flip to the right and they need a follow up plan for BMI management or communication supervisor for dietary consultation.

You do not need to include patients in this if they are terminally ill or if they have an active diagnosis of pregnancy, which a lot of people get a kick out of the fact that an over 65 may be actively pregnant, but that’s part of the rules. And, if for some reason you didn’t do a physical exam it wouldn’t be required as well. Over 65 normal weight you get that numerator, but if they’re outside the range, above or below, then you would need some type of intervention for them to count your numerator.

The second half of that is for patients between 18 and 64 and the only difference for this one is that the normal range goes from 18.5 to 25; otherwise, it’s the exact same measure, just different definition of what’s normal for a person between 18 and 64.
Again, if you’re a pediatrician you may not have people over the age of 18, so you would report on one of these. This one is for children in adolescence for weight and activity. Essentially, it’s a measure that’s looking at children ages 2 to 16 as one group and then they divide that group in half and you can see population to is to attend and population three is 11-16. So it changes to one group and splits in two halves.

So you have three denominators in this particular measure, and for each of those denominators you have another numerator, so you actually have nine measures on this particular one. You need to document that you have a BMI for one measure. You need to counsel them for nutrition, which is another measure and you need to communicate for physical activity, like do a little guidance on exercise and activity.

Again, pretty straightforward just document that you’ve done these things and this is for all kids in that age and you want to do that during an outpatient encounter, sometime during the measuring period when you’ve seen them.

Influenza immunization is for whether or not a patient has received an influenza immunization during the influenza or flu season.

The last one has lots of numerators, 12 measures that are basically measuring whether children between the age of one and two are up to date on their immunizations. When we look at some these specific measures we see, for example, for some of them you need to have problems on the problem list. You need to actually develop problems for the hypertension one and some of them require documentation within the chart that you’ve done certain things.

For example, here you need to have documentation of shots and other information that’s required for these measures.

So what is the core and alternate core for the stage I Meaningful Use that starts now and the end of 2013. The additional measure you get to select free from. We’ve divided it up into groups and this one group of additional measures, focus on diabetes. You can see the first and last one talk about hemoglobin A1c, is there over 9, which is considered poor control or under 8, which is considered in control.

Other things that we want to do for diabetes is measure their low density lipoproteins or LDL and make sure their blood pressure is under control. Testing for retinopathy or, if you’re a specialist, and you actually do a retinopathy exam you want to communicate your findings back to the primary provider, for managing the diabetes. You want to have an eye exam, urine screen and foot exam for patients with diabetes.

There are also quality measures that focus on cardiovascular disease. First is coronary artery disease (CAD), use of beta blocker therapy for patients with MI, because we know that that actually improves their long-term outcome. Oral antiplatelet therapy for patients with CAD and drug therapy for lowering LDL-Cholesterol, which we also know reduces the risk.

For patients with heart failure, beta blocker therapy for left ventricular systolic dysfunction. Again, we know that improves longevity. ACE inhibitors or ARB therapy for left ventricular systolic dysfunction and Warfarin therapy an anticoagulant for patients with Atrial fibrillation, because the regular beating of the atrium of the heart can case plaque to form in patients with heart failure.

Last, for patients with vascular disease, again we have blood pressure management, the use of aspirin or another antithrombotic to prevent loss and again, a complete lipid panel with LDL control. So again, we want to delay any further vascular disease by controlling the blood pressure well.
Some preventative measures that are in the quality measures are listed on the next slide.

- Pneumonia vaccination for older adults
- Breast cancer screening
- Colorectal cancer screening
- Cervical cancer screening
- Clyamydia screening
- Prenatal care includes screening for HIV and anti-D immune globulin

There are some other ones for appropriate use of medications or studies. For example the first one is…

- Appropriate use of antibiotics for children with Pharyngitis and not just prescribing Amoxycillin for kids with a sore throat before you do the test.
- Over use of bone scans for patients with prostate cancer and for staging low risk cancer patients
- The use of high in cost or high intensity for studies of patient’s with low back pain causing unnecessary exposure to radiation.
- Finally, asthma for pharmacologic therapy, asthma assessment and appropriate medications used for patients with asthma.

The last group you can see on the slide are for a variety of things.

- There’s one for Oncology: hormonal therapy for those with estrogen receptor cancer, positive breast cancer, chemotherapy for stage II/III colon cancer.
- There’s one on smoking and tobacco use: advise patients to quit and discussing strategies.
- There’s initiation and engagement for alcohol and other drug dependence treatment.
- Then there’s the appropriate management that patients who are on anti-depressant medication for depression.
- Primary open angle glaucoma and adequately controlling blood pressure.

So this is sort of the string of the measures, which are all part of stage I. However, as I mentioned, not all electronic health records are necessarily certified to do all the additional measures.

Let’s talk just a minute about certification and what it means and how it impacts on your particular measures. Meaningful use has a number of certain criteria, up here for example, we have some of the criteria that are required for Meaningful Use. In the left hand column is E-Rx, provide patient summary record of their care and electronically submit data to immunization registries. All these are requirements for Meaningful Use. All are related to managing patients well, creating a healthcare home and doing things that help you manage your patients.

In order to do that and be able to report and produce those things in a consistent manner so they can be communicated with other places, there needs to be standards, so the center column you see in the example are the standards, in order to be able to execute on these elements.
We have standards for E-Rx, continuity of care documents or summary records and also standards for submitting immunizations to the registry program.

Once these standards are posed for these elements, one then must then certify electronic health records to say that they include these and they're able to do these things appropriately, which is what certification for EHR means. It essentially means that if they have the appropriate standards within the electronic health records to produce what is being asked for.

To achieve Meaningful Use, you must use an ONC authorized testing and certified body to see if your EHR is certified. There are listings. All of you folks I’m sure, since you’re at the stage progressing towards Meaningful Use, you should have one right now. You may be familiar with going to the site. For example, you would click in the lower left and select the ambulatory practice type. That will then take you to the search page, where you can search in the center for your particular product.

You can browse as opposed to searching, is quicker. So if you really want to search for a particular product you need to click the search button. As we browse you'll come to this page, as you as you see here, and on the left you'll see the certifying body that actually certified the product. You'll see the vendor, the product, the actual product name in the third column that's hyperlinked, along with a version and whether or not it's a complete EHR or modular EHR.

And as I think you all know, you have to have a complete EHR, in order to be able to be able to attest to Meaningful Use. There’s a little bit of a gotcha here that many folks didn’t realize, so if we looked at the second item here, 1 Connect HePoEx EHR, I don't know anything about this product. It's 3.0. It's a complete EHR, but in order for it to be a complete EHR, you have to use the additional software that's required, which is MS Online Services, MS Info Pass 2010, all applicable requirements.

So, what you'll see here is that in the product it may be certified as complete, but you still need to purchase additional software, to be able to have what is called a complete certified electronic health record.

You've probably done this as well. Let's say we click on the first one. They are a modular EHR, so if we click on the right Add To Cart and then click on the cart, we come to a page like this. This page describes what criteria the EHR has been certified for that's in blue and as you probably know, on the right hand side EMS-EHR certification ID is gray, because it's not an EHR and you can see the percentage of criteria currently met at 28%.

Then you would need to add more modules until you came to 100% and then you could do a complete EHR. If you look at what would be further down the page for a complete EHR, for stage I, we see the general certification criteria that I talked about on the left and the ambulatory certification criteria on the right. So you can see that this is a complete EHR.

Many folks, when they purchased their EHR thought you know what I bought a complete EHR so I can do everything I need to do for Meaningful Use. However, one of the things they didn’t realize if you scroll down the page you'll see there’s a difference between the two complete EHRs on the left and right side. Essentially, what we're looking at right now is the quality measures for which the EHR is certified.

Some vendors, as the one did on the right, certified for everyone one of those vendors, so when we were talking about all those additional measures, you could select whatever measure you wish, in order to be able to report your quality measures. However, if you selected the EHR on the left hand side you may not be getting measures that you find are meeting your needs.
To be a certified EHR they need to be able to report on the three core, the three alternate core and any three of the 38 additional measures and are to be certified. So as you see on this particular one, the one at the very bottom if you can read it, diabetes control, hemoglobin, A1c under eight is one of the additional measures. Another additional measure is diabetes eye exam on the one on the left. Another one is tobacco use cessation, which is around the third check mark from the top.

So, with this EHR you would have two diabetes measures if you’re interested in that. If you’re a cardiologist or someone who’s more interested in heart disease and heart failure, you’d really have no certified measures to be able to report on.

Now that creates problems for folks, because they’re winding up with lousy numbers on measures that they didn’t really want to look at or sometimes zero is the denominator. I think you may be aware that there was some frequently asked question released by CMS saying that people could submit numbers for measures that had not been certified if they wished, but they were not required to do so. So you could conceivably, if you were into heart failure, submit those three numbers from that EHR on the left even though it was not certified to do that.

**Why these measures matter**— I think many of you may know this but I think sometimes its good to reinforce it with the providers who are sometimes in the throw of trying to keep up and get their work done. This is not just a hoop to jump through just because there’s a hoop, but it’s actually stuff that will improve patient care.

So, one of the comments we had from one of our providers says the pace of clinic is very fast and its easy to overlook things. You can see a quote from this doctor on the slide that states...’We finally got all our diabetic reports working. If you would have asked me before I saw these reports, I would have said all my diabetic patients have been prescribed low dose aspirin. The report told me that 14 aren’t” He’s actually doing pretty good he actually recorded it on a large number of diabetes patients, because many of us would have them on aspirin, but not even have it on a way they could be retrieved for the EHR.

Most of us providers believe that we provide above average care, not just because we live in Minnesota but because we try hard and we try to do the best that we can. The bottom line is, when you see reports sometimes, and we talked about this last time it’s a real eye opener to see those patients at oh yes, this person was just in and we didn’t talk about that and didn’t even think to ask them about that.

One of our colleagues in the extension center actually put this data together to try and bring home. He tells a story about Joan, a previously healthy 48 year old woman who works as a school custodian with no significant medical history. Over the last four months she has experienced blurry vision, frequent urination, weakness and constant thirst. She went to see her doctor who discovered her blood sugar was 455 and her hemoglobin A1C was 10.3. And I think you all know that those are pretty high. The diagnosis of new onset diabetes was made and she was started on metformin and insulin.

So, the measures that would count towards this, you have four measures to look at.

- Diabetes: HbA1c Poor control over 9
- Diabetes: HbA1c Control under 8
- Diabetes: LDL management control
- Diabetes: Blood pressure management

These are the four that we could release this patient right away. So, what does it matter? A1C: A 10-yr follow up study done in the UK showed sustained benefits of intensive strategy to control insulin levels. Ten years after cessation of the intervention, these benefits included reductions in microvascular risk, myocardial infarction and death from any cause.
So again, by controlling that, we can protect their hearts and death from any cause.

An analysis of almost 19,000 individuals with diabetes were followed for an average of 4.3 years and showed that a 1.5 mmol/L, which is actually 58 mg/dl reduction in LDL cholesterol would prevent approximately a third of patients from having a major cardiovascular event. So again, that means 1 in 3 people over 4.3 years would not have a heart attack if their lipids were lowered by 58mg/dl. That’s still significant.

Another study was where participants were followed for an average of 13.3 years and showed sustained beneficial effects with intensive interventions that included targeting hemoglobin, cholesterol and blood pressure, including: a 20% absolute risk reduction in death from any cause, which means 1 in 5 people wouldn’t die; and a 13% absolute risk reduction in death from cardiovascular disease, meaning 1 in 8 people had a death from cardiovascular disease prevented. Again, not insignificant.

How do you begin to operationalize this? This is going to be one of your tasks going forward. This is just a simple example that’s in a couple slides, you can choose any method that you might want to do this, but this is something that Phil and I put together really quickly. I scribbled on paper with a pencil and then Phil helped make it look good.

So, you have what we call the ‘swim lane’ and you can use this to figure out who does what particular activity or who does what function on a visit. For example, this was a patient presenting to the visitor who we know has diabetes. The patient is marked by reception, so the front desk can give them the pre-visit summary. The certified assistant opens the chart in the exam room and prepares for a visit by printing the face sheet. Actually, the face sheet is given to the assistant who picks it up from the front desk.

She brings the patient into the room and the assistant reviews the chart for open orders. If there are open orders she’ll send the patient to the lab and then ask the patient upon their return and she sees the patient is diabetic, one thing that works in our clinic to help remind me, as a provider, the patient is diabetic and I need to address diabetic issues. You’d think having it on the chart would do it, but it didn’t necessarily because I sometimes miss a patient with lots of problems, what they were there for.

The medical assistant would ask the patient to take their shoes off. So they’d be sitting on the exam table with their shoes off, which was a big reminder to me. They would get their weight, blood pressure and pulse and add that information to the chart; note the height is already in there so they’re able to get a BMI. The reason for a visit, reviews tobacco, offers any interventions or reviews and updates with the patient, the allergy list with the patient and also looks at any health maintenance things that need to be done queue’s up any orders.

Not to actually order them, but gets them queued up so the provider can assess and assign them when they’re ready to write their orders for the patients. When this is done, again the patient is sitting on the exam table, the nurse can leave the room, put that sheet of paper against the wall in the chart rack for privacy rules and let’s the provider know the patient is ready.

So the provider then picks up the chart and is able to see why the patient is there, is able to see who they are now and review any of the items that were due and can cue up the new labs that are waiting. The provider does the exam and looks at any other items that need to be addressed and orders any particular items they feel need to be done as a result of the exam.

Then the provider reviews things with the patient during the visit and recaps with a summary that’s complete. The patient will either, being going to the lab at that point potentially for additional lab work or be going home in quality health and knowing their follow up plan.
So that is the example of a flow sheet that could be used just to be able to collect some of this data. So if we look again at this flow sheet, as we go back we can see that we’ve got the reason for the visit, we’ve already sent them to the lab for getting some tests because there are often orders done. This is a patient we know is diabetic and if they have open orders they’re probably coming in fast so they can get all the information they need.

We’re collecting again the height and weight information so we can do a BMI. We’re doing the tobacco screening and work in here. We’re checking the med list, allergy list, and because the patient’s shoes are off, I’m doing a foot exam if needed and also cueing up any other labs. So, we have the opportunity now to be able to address the patient’s diabetes and lower their A1c down to an appropriate level as well as get their LDLs down to an appropriate level.

So again, this is just an example of a swim lane so you can see how things could potentially be done, in order to achieve Meaningful Use.

With that, I’m going to hand it over to Phil.

**Phil Deering:** I’m Regional Coordinator for REACH and we’re working with a tremendous number of clinics in both Minnesota and North Dakota.

A potential issue is that the providers still see these Meaningful Use requirements as just adding additional work and can’t quite see their way through to getting all the work done and providing the patient care that they really know they need to provide. We believe that by working through these flow charts within each clinic, if you review the requirements and work towards getting every member of the clinic at the top of their license, cue up all the information so that the provider is ready to walk in and spend a maximum with a patient.

And then, can relatively easily click off those final elements in the EHR so that the documentation is in place, orders are made and then lo and behold, information will be sent by the HR to the quality measurement section of the EHR so that these quality measures can also come out and help provide a feedback loop to help the providers and staff to make sure they’re doing the right thing for the patient.

That’s the point of this exercise. Perhaps the one we showed you may not necessarily be the one that works for you, but by thinking through it, we find the greater majority of our clients can get this stuff done.

**Dr. Kleeberg:** Right. Great point.

**Jerri Hiniker:** We’re going to do some discussion on how everyone is doing. We have a few discussion questions that we’d like to share with the group. With that, I think starting off we’ll open the lines so the participants are able to share. To start, if anyone has questions on the presentation we just completed, we’ll take those first and then go into the discussion questions.

In regards to the discussion questions, I believe many of you are doing quality reporting, what we’re trying to do is find out if you’re sharing those quality measure reports with your providers and if so, how are you doing that?

Is it like a one to one session?
Are you sharing it in aggregate with all of your providers?
Did you share individual data?

We’re trying to find out how people are using this data and how effective it is in the ways that you’re sharing it.
Stephanie Juriskowski:
Hi everybody. I’m just going to see if I can touch base a little bit on the questions that you’re asking. Again, I just currently started this quality position here at Lakewood, so I’m new. There was someone who did share the quality reports with the providers and they did it in different ways. I do know they also did an overall group reporting, letting the entire group know how they were doing and then there was also some shoulder to shoulder, elbow to elbow discussion of how they were performing individually.

I know that was back, from what I understand, in the September/October period and it’s been kind of a transition phase going on right now, and I’m just now taking this over so I think there’s a bit of a lull in there. I came on board when we did our Minnesota measure reading for diabetes and cardiovascular, and we’ve been getting reports back from that, so I’m setting up an action plan of how we’re going to be doing the training of our providers.

I don’t have a lot of answers for your questions, but it’s a work in progress here which is why I appreciate so much your discussions, because I’m learning things on other areas and what they’re doing.

Jerri Hiniker:
Stephanie, have your providers already attested to Meaningful Use or are you in that process also?

Stephanie Juriskowski:
I believe they’ve already attested. Again, our Director of Nurses, Deborah who couldn’t be available for the call today, did take care of setting that up. I believe that’s been taken care of.

Phil Deering:
One of the questions or an issue within the way clinics operate in their individual cultures. Indeed, I think it’s relatively common for people to share the overall clinic numbers and as we know, since you’re on Minnesota Community Measurement it’s hard to keep them a secret.

Nonetheless, I’d just love to hear if anyone thinks their culture would support this is actually a provider meeting once a month where all the providers get to see each other’s measurements on the things you’re tracking.

Has anyone tried that? Does anybody think their culture would not support that?

Lori Dell:
Hi, yes this is Lori Dell from the Mankato Clinic. We have a larger group participating, we’re just not all in the same room. I invite their assistance with this as well. I actually had a question before you posed your question, but I’ll answer yours first.

We actually share our quality data at a provider level, transparently across all of our primary care providers. We have approximately 25-30 primary care providers and our quality department produces the reports and its transparent, everybody’s name is there and we see how each provider is doing on each of the measures.

We’ve been doing that for over a year, probably closer to two and I think it went pretty flawlessly. I think it was a bit of an adjustment but our Chief Medical Officer and our CEO talked about the importance of transparency and quality of improvement and set the stage for this, so everybody was on board with it.

Phil Deering:
That’s terrific.

Lori Dell:
My question then goes back to one of your earlier slides where you were reviewing the measures and I don’t know if I recall the details specifically, but my concern relates to the difference in the definition of measures from different entities. There is a variation in the BMI measure that you are looking for, compared to what we report for Minnesota Community Measurement and Blue Cross Blue Shield.
There’s a variation or difference in the tobacco cessation or smoking tobacco use question as well. They’re subtle differences but that can mean a lot to those of us that are trying to report on all these things and trying to interpret that for the care teams, who are trying to do what’s right and figure out the measures are all defined and understand what they truly are.

**Dr. Kleeberg:** I hear your confusion and I understand that confusion and dilemma. I can also say that CMS and ONC are aware of that problem and are hoping to begin to resolve that going forward. They did hire a physician, Kevin Larson from Minnesota, to go to Washington to help harmonize these measures. It won’t happen within the year, because right now all the measures within Meaningful Use have 2011 software. It’s hard wired and can’t be changed until 2014 our reporting year.

My message to you would be, the measures that right now really count, I would say, if I were your director right now, the measures that really count are the ones we’ve had the most experience with as Minnesota Community Measure; the ones to the insurance companies. Those are the ones who are going to look at our performance. Right now, Meaningful Use does not pay for performance it pays for reporting. Therefore, you can have lousy measures and you can actually provide better care than what the measures may indicate and you won’t be penalized for it. Initially, when you signed at the station that you were attesting to the accuracy of these numbers, but the way the wording has been changed as opposed to saying you’re signing that this accurately reflects my practice, you’re attesting that these numbers accurately reflect the output of the EHR.

They do not want you and are not asking you to redesign your work flow just to meet their particular measures and I wouldn’t be surprised if one of the reasons around that is because many of us who have been using EHRs for a number of years have already refined our workloads to meet the measures that have been placed for a while, and they don’t want us to redo everything because these new measures have come out.

That’s probably another reason why the measures that have come out for 2011 and 2014 are going to remain to provide you with any guidance and reassurance.

**Lori Dell:** Well yes, thank you very much. I’m happy to hear that you acknowledge this and that you are working to harmonize those measures, because to the extent that we can be consistent and have a standard definition that will make everyone’s job and understanding all of this much easier. Thank you.

**Dr. Kleeberg:** Yes.

**Cynthia Kasan:** I work with health clinics and we’re a little more specialized. My question centers around…I’m confused after looking at the literature and even after your presentation. In terms of, if you don’t have reporting zeroes for the core measures, do you need to then provide six things from alternates or do you get to count the zeroes towards your total? If you could clarify, I mean, are we supposed to have six or nine?

**Dr. Kleeberg:** You need to report three additions regardless. You need to report, if you have three or more zeroes in your core, you need to report all core and alternate cores. In other words, you’re going to be reporting nine measures total.

**Cynthia Kasan:** Okay. With the three zeroes as part of those nine.

**Dr. Kleeberg:** Three or more, I mean, it’s conceivable that you could have nine zeroes depending on the practice.
Cynthia Kasan: Okay. That was my question, because we are so specialized that we were trying to think of workflow, and altering it so to your last response I was relieved to hear we don’t have to create new workflows or add-on just to meet, to provide less zeroes. I believe I’ve summarized that correctly.

Dr. Kleeberg: Yes you are correct. The other thing as well for 2014 certified software that I have to see how they’re going to make this true or, is that they claim it was very prescriptive in the 2011 software where you had to answer the question in order to be counted and my understanding is that there’ll be more flexibility, more in the workflow for the collection of the measures for 2014.

I don’t know how they’re going to operationalize that within the EHR, but they did recognize that providers almost had to go through contortions in order to be able to document that they did something within the current version of EHRs.

Phil Deering: Exactly right. CMS and ONC have made it very clear that if your EHR, your current 2011 certified version of your EHR is requiring you to take steps to document activity that would be outside the normal workflow or cause you to feel that you’re being inefficient or ineffective in providing care to your patients, then you should not do that.

Cynthia Kasan: Okay. Thank you for the clarification.

Phil Deering: I want to take a quick poll and because earlier we heard that some people weren’t doing cardiovascular measures, we’ve been thinking of moving ahead and using diabetes measures as the core of this LAN. I wonder if we could go through the list and ask people if diabetes measures are appropriate if we’re going to use a set of measures to continue to deepen our understanding of quality measurements.

I see Amy. Do you know if, continuing on with this LAN if diabetes measures would be appropriate for you and your unit? We have great problem solvers everywhere.

Dr. Kleeberg: The question is, would we want to continue on with diabetes or reconsider cardiovascular or, maybe we can potentially do a number of the different ones just to do as an example.

Amy Ulee: Yes, I think it would be appropriate.

Phil Deering: Great. Harv Anderson?

Harv Anderson: Yes.

Phil Deering: Cynthia?

Cynthia Juriskowski: Yes.

Phil Deering: Great. Lori?

Lori: Yes.

Phil Deering: Tameka?

Tameka: Yes.

Phil Deering: That’s good.

Jerri Hiniker: Are there any other questions, I have a few slides to go over before wrapping up?
I want to mention there will be a link sent to you via email with an evaluation that we’d like you to fill out for the webinar. Another thing we would like everyone to do is to look at the workflows that were part of the webinar today and show us how your operation lies in that, in your facility. You can send that information to myself, I’ll include my contact information in a bit in Minnesota and Connie Dyer in North Dakota.

It doesn’t have to be anything fancy. We’re just looking to see how people are doing this work in their facilities.

**Phil Deering:** Don’t worry about making flow charts, front office space task, CA task, provider task, etc.

**Jerri Hiniker:** We just want to see what works for you. I wanted to put out for you a schedule that we have for the dates and times for the upcoming webinars. There are 10 schedule, which goes through December of 2012. We will also be posting them and sending via email. This way you can get them on your calendars.

There are titles for the majority of them so you can see what they’re about, but know if something comes up that you really want to learn about instead of covering Harmonizing Measures in December, we might put that off until February and cover a topic that you would like to learn more about at that time. In the evaluation it asks if you have another topic you’d like to cover.

**Dr. Kleeberg:** One of the topics that we started talking a little about is problems. They are the driving force behind many of the quality measures, in order to identify the patients we need to be targeting. If you’re interested in that topic, which can be important for places that have patients who are sharing their EHRs, we can have that as a discussion.

**Jerri Hiniker:** We will post this to Base Camp also, so if you see it on Base Camp it may look at little bit of change in the topic from what’s listed here. We’ll also remember to send out reminders prior to the webinars.

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Again, our next webinar is on August 27, 12:00 to 1:00 and we’re looking at overcoming barriers to find out where your pain points are. If there are no more questions, we’ll wrap things up for this webinar.

Thank you for attending. Have a good rest of your day.

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