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**Understanding Clinical Quality Measures/ Meaningful Use Requirement for Hospitals**

Presented by Phil Deering and Sarah Tupper, Stratis Health, *40 minute Webinar* *03-27-2012*

**Phil Deering:** Good morning I’m Phil Deering and I work for the Regional Extension Center for Health Information Technology Reach and I’m here with my colleague Sarah Tupper, who is one of our field service consultants. We’re going to talk about the quality measures associated with the eligible hospital side of the push for meaningful use of electronic health record technology.

What I thought I would do, because you’re an interesting audience and are especially from big hospitals that are normally outside the scope of our work, I wanted to make sure we started by you asking questions you have about meaningful use. Sarah will write them down and I’ll go through my presentation and then we’ll see if we’ve answered most of those questions.

Some we may not be able to answer but we’ll take that as a parking lot and get back to you, but we hope we’ll be able to answer the majority of them during the presentation or we can have some discussion afterwards. Also, please at any point feel free to interrupt me or stop me if something I say doesn’t sit well with you or is confusing and we’ll review it at that moment.

**What is meaningful use?**

**Sarah Tupper:** Maybe how or why they don’t align with the national hospital measures.

**Phil Deering:** Okay, so why the current set of quality measures don’t align with the quality measures you are now reporting on? Are there any other questions? Then let’s get started. What I want to do is spend a little time talking about why we’re having this meaningful use thing and then I can talk about the program and as we go feel free as something comes up to let us know so we can try and get it answered for you.

We’re going to do a brief history lesson about healthcare quality in the U.S. I think many of you remember back in 99’, you probably heard about this study where it seemed to be that in the U.S. we were actually killing through preventable mistakes, thousands of people every year and in some of my presentations, like when I go to Normandale College and talk to students there, I have a slide with crashing 747s and I did the math once, but its something like 700 747s full of passengers are crashing every year and that’s the number of people that are dying from preventable deaths in our hospitals.

It’s very upsetting and something that’s been going on for a long time. We’re sort of flying below the radar because if those are plane crashes then the whole nation would come to a halt to try to deal with it, which was one of the pieces of evidence.

Since that time there have been a series of studies and evidence-based articles that have come out which indicate that we can both that we continue to not provide the kind of quality we wish we were providing and that patients wish they were getting, but at the same time that the need for computerization to bring technology to help solve those
problems was being made clearer and clearer by numbers of the numerous studies that were going on.

By 2009, Barack Obama was standing up and publicly claiming that we needed to enter into this push to get all providers of healthcare in the U.S. up and running on electronic health records.

It’s interesting that many of us think that this is part of the Obama administration and don’t realize that actually the push for electronic health records started much earlier and both the Bush administrations had antecedents where they were pushing for more and more people to get on electronic health records. So it’s nothing new, but finally now there is a very organized program to push the nation in that direction.

I think we all understand that in addition to quality there’s a couple other problems going on with our healthcare system and we all know that one is cost. It’s unavoidable and I think at least people with hair and my color also understand that this cost issue is only going to get worse.

I heard Robert Reich talk about this and he called the baby boom the pig that’s going through the python. There’s this huge group of people that are now getting older and sicker, it’s awful. We’re all ashamed that it’s happening to us, but nonetheless it is happening, so what we’re going to see obviously is increasing healthcare costs in the U.S.

Compared it to other nations, this is one study but there are many other studies that indicate clearly that we spend more per capita than any other nation in the world on healthcare and it’s an undisputable fact. The quality of the care that’s provided in the U.S., there are many ways to look at that and it can be a very controversial subject. Nonetheless, we know that on many important measures of overall health of a country we aren’t doing very well.

A WHO study dated from 2000, while the U.S. is spending the most on healthcare, we are 37th in world and life expectancy. Again, many of you have heard many of these studies so there’s something gone wrong, costs keep going up but quality and our ability to keep a healthy society isn’t tracking along with the costs.

Next is something that was surprising to me and I bet it is for most of you as well, that it turns out when we look at the expenditure that’s being made in technology, per capita spending on health information technology the U.S. ranks very low compared to other industrialized nations. It’s interesting those nations that have lower healthcare costs per capita, seem to be spending more on technology.

When I first saw this it amazed me, because we are the home of technology but nonetheless it is poorly deployed and again in Minnesota I used to…people know what rank Minnesota is in the nation as far as the adoption of electronic health records? We can pat ourselves on the back and to a large extent here we’re talking to the convince, but still our spending is low and especially when you get outside of the big integrated delivery networks.

In Minnesota when we get into rural areas and all those other areas we find that people haven’t been able to make those investments in technology that can provide the additional information that can help track quality in all accounts.

In addition to the cost and quality issues it turns out the consumers also want electronic health records. Some people don’t, but in general if you talk to people they love it. Many of you probably are in an epic system for your care and have a my chart thing and you know how fabulous that is. It turns out there’s a lot of information that says in addition to this government push there’s a strong consumer push.
When we’re talking to physicians that are reluctant to implement electronic health records, we ask if they really think in five years they’ll be able to practice medicine without an electronic health record. Everybody says no but there are some who grumble and say I’m going to quit before then, but no one really thinks we’ll be able to move ahead without electronic health record technology.

There is lots of evidence and its continued to be updated that health information technology has the potential to improve healthcare quality, prevent medical errors, increase efficiency healthcare provision and reduce unnecessary healthcare costs.

What happened? With the stimulus package there was a tremendous amount of money put into what’s called the hi-tech back, $29 billion dollars so this is a big bet due us as a society to invest in health records technology.

How is that money being spent? Let’s start with the fact that most of the money is being spent on this inaudible for what’s called meaningful use of electronic health record technology. Basically, under that program there is a Medicare and Medicaid program and again because its from the Federal government the two things that the Feds pay are the two areas they’re using to incent and/or penalize providers when they adopt or fail to adopt electronic health records.

There’s a process or meaningful use program for hospitals and critical access hospitals and there’s one for healthcare providers. There are many permutations within them but in general, everyone on the individual's side on the eligible provider’s side, anybody who can write a prescription is more or less mandated to be using electronic health records by 2015. On the hospital side all hospitals with some exceptions, which will tend to go away as we approach 2014/2015, hospitals also have to meet these requirements. Initially there are incentive payments, but in 2015 penalties start to kick in and if eligible hospitals do not meet the meaningful use requirements then they will be penalized.

In addition to this core system of incentives and penalties, also the law established a Regional Extension Center so there was acknowledgement that there needed to be consulting help to help get people to be able to adopt electronic health records. There aren’t enough people in the workforce so there is workforce training going on in Minnesota.

The blue are advanced practice grants that are also being pushed out as well, so there are grants that go to the states to encourage the exchange of health information and to set up the infrastructure to allow health information to be exchanged between users of that information. In addition, standards and certification bodies are put in place and privacy and security continue to work to make the law both more able to protect the privacy and security of folks, but at the same time to make sure privacy and security concerns don’t stop the free-flow of information where necessary.

Meaningful use is basically these three things…

1. You want to use certified electronic health record technology.

   There is a large group of people that test and certify the technology, but you can’t just use any technology you have to use absolutely the certified version of that technology.

2. You have to have it connected in a way that allows for exchange of information through your technology out of and into your technology.

3. You have to deliver clinical quality measures to the Federal body's that are mandated to receive it.

Right now that is CMS, but in the statute its defined as the Secretary of Health and Human Services.
In addition to the quality measures there are 14 hospital core measures that the people who are caring for the patients need to do, so there’s everything from CPOE to needing to have clinical decisions, support rules turned on and drug interaction, drug allergy interaction and there are requirements to be able to demonstration the exchange of information in that core group of requirements.

In addition there is many of groups of inaudible requirements of which eligible hospitals need to comply with five of those measures and again these are not on the quality measure side but more on the transactional care requirements. Then finally, there are these 15 quality measures for stage one meaningful use that we’re in currently. The law establishes three stages 1 through 3 and over time the concept is that the requirements will become more difficult to reach and there will be more precise requirements and then finally the outcomes of the requirements will become more difficult to reach or more demanding over time.

We call it the meaningful use escalator. Initially we start at a basic level that is just install technology and demonstrate the ability to collect information and structure data. Then finally to be able to demonstrate the ability to exchange that data and that’s stage one. In stage two what we’re seeing is additional requirements and much stiffer requirements around the exchange of that data and then stage three, although it is not set, we expect to see outcomes being measures, whereas right now we’re only collecting and reporting outcomes, but there are no thresholds for successful outcomes.

Stage one at least exists through 2013, depending on when you start stage one you can move to stage two a little more rapidly, but we will see starting in 2013– and for many of you represented here as partners– all of your organizations are well on the way to stage one and almost all have tested on the hospital side or are in the process of doing it right now.

The quality measures are setup to align with both meaningful use, which are effective, safe, efficient patient centered equitable and primary care. The eligible hospitals are required to submit 15 quality measures and there are not choices you have to do all 15.

In 2011, eligible hospitals are required to report summary data that's true, so there is no need in 2011 or 2012 who are actually now in stage two, to report the details behind the data nor is there a requirement to present to hit certain measures for that data. What you report is a numerator and a denominator and that’s it.

In addition to the Medicare program there is a Medicaid program and almost all your hospitals will be eligible at least. Almost all of you will have some hospitals in your system that will be eligible for the Medicare program and many of you all your hospitals in your system will be eligible for the Medicaid program. Under that program you then report to the state, although the requirements will be the same but you just have to go through another facility to get that data to the state, because the law requires that the states administer the program.

All the measures have specifications for electronic reporting so I’m not going to go into these in detail. In my presentation, there are 15 slides hidden in this presentation that are the details of those measures. If anyone wants to talk about the details we can but I’m not the detail guy. This is actually a 34-slide presentation but we’re only going to see 11. Should anyone have problems being able to figure out what the details of the measures are please get a hold of this, but I believe you have people in each of your organizations who is charged with knowing what these details are.

Reporting is limited to patients in the HRT may have some areas of the hospital that still aren’t on the technology side. In Minnesota this is relatively rare, but it may be so if there are patients that still are on paper in some corner somewhere those are not mandated to be in this reporting pool.
Although the program only in a sense is based on patients that are either Medicare or Medicaid payments, the quality measures are based on all the patients in the hospital, so it doesn’t matter who the pair is you report the denominator essentially as all those patients regardless of pair, what’s the condition that is being measured.

It is possible to have zero denominators in the measures and there is a method to attest to this. This is especially true with critical access hospitals amongst our clients, where I get if you look at the measures I think a fair amount of you have looked at the measures so they are around stroke and VPE, those sorts of measures and there are very few patients in critical access hospitals that have that.

Since the initial period was 90 days, many of our clients in critical access hospitals have zero denominator and they’ve gone ahead and tested to meaningful use, so that’s accepted.

The measures are the same for the Medicare and Medicaid program, even though they are two separate programs. You only report one set of quality measures.

They are aligned with IQ, inpatient quality reporting measures; however, I took that off a CMS website and perhaps that’s wrong because there’s a question like, why don’t these align? So maybe I don’t understand all the measurement programs you’re required to report to.

So here they are, are these new to anybody in this room? No, good. They are all from the national quality forum and part of the reason for that was that these were e-measure ready, so the quality forum had them designed, a data dictionary and data flow associated with them that could then be presented to the vendors of certified electronic health record technology.

ONC, which is part of CMS, the office of the national coordinator that is responsible for this meaningful use program, they moved to the national quality forum measures. I know that some quality experts, for example, in Minnesota we have inaudible and there are multiple places and organizations that developed and vet control quality measures and there is a push to expand whose quality measures we might look at over time, but in stage one these are the measures in descent.

Here’s what’s different than other types of quality reporting that you may be doing. The numerators and denominators have to come from your certified electronic health record technology. The only way that you can use other methods to generate those numerators and denominators is if you go and certify the piece of software you’re using that is touching those measures.

So, no matter what comes out of those measures, no matter if you know what’s wrong and want to manipulate it you can’t. The requirement is for that. There is no passing threshold, so if you have one patient out of 10,000 and one is in the numerator that’s fine, no one is scoring that. The requirement is to deliver the measures that came out of the certified electronic health record technology.

In addition, initially there was a little waffling on this, but CMS has made it very clear that there is not an expectation that providers, the hospital staff will change workflows to accommodate the measures and make sure the right numerators and denominators are going into the measures. Does everyone understand why that needed to happen?

What the quality measures…the notification of the final rule came out in summer 2010 and the first people wanted to be able to attest in January of 2011. To accommodate these new measures that often work in the technology that was in place, vendors often suddenly put checkbox data fields in strange places or actually are calculating the measures based on a few of the technology that doesn’t correspond to the way its being used in the hospital.
So, with regions they were using there so they have FAQ and they were getting their stroke measures but it was like no, whatever we’re getting 10 stroke patients a month and they’d be like we know that’s wrong. They burrowed into it and realized that they classified stroke under a completely legitimate thing, doing best practices on stroke and getting all sorts of quality measures but it wasn’t the way FAQ was counting stroke patients.

What CMS did then was to say you don’t have to change the way you work in stage one because we know vendors did wacky things and we don’t want anyone to put patients at risk or to cause huge amounts of extra work, in order to accommodate these measures. In this is actually some guidance, an FAQ that further clarifies this, this is so odd that we get a lot of questions about it so if you have anybody who’s questioning this then you can point them to this FAQ from CMS.

At this time CMS requires provider to report clinical quality measure data exactly as its generated also from the certified EHR technology, so that’s the thing. The good news is for you who have to do work is that you don’t really have to do any work. You have to make sure the measures are turned on and then you have to essentially write down the numerator and denominator for each one of these 15 measures and then at some point plug it in to an attestation facility.

When the rule came out originally it said that in 2011 the measurement would be recorded, the requirement was only to attest, so essentially a manual data entry right here, EHR technology produces numerators and denominators and percents, and the requirement was then that you would manually enter those into the attestation field.

When the initial rule came out it said in 2012 you will then do this electronically, because a key part of your certified EHR technology an inherent feature of it is its ability to communicate electronically. Therefore, the notion was that CMS was going to set up the facility that would then allow your EHR to electronically talk to this facility and the quality measures would be automatically reported.

That didn’t happen, so continuing in 2012, you’ll do that through attestation. There are some electronic reporting pilots. None of our clients are using them that we understand right now. Is anybody now know that in 2012 you’ll participate in a meaningful pilot for electronic reporting? No. So again it won’t be a manual effort so the first time you’ll have your measurement period be 90 days and you will then declare that 90 days. You will get the reports for those 90 days and then someone will enter the numerator and denominators as well as exceptions for each of those measures.

Then, after you do that, next year the following year will be for the full year and you will report those periods in the following January through the end of February of the following year and again it will be manually entering those numerators, denominators and exceptions.

If you want to get involved in the pilot I have a link to provide you with here.

Each of you should have somebody who is working with Reach. They should have received the communication with the call-in information and that’s one way to find out about stage two. Basically, the deal with hospitals for stage two which will start no earlier than 2013 is that, instead of 15 quality measures there are going to be 24 measures. The proposed rule, which is the stage we’re in now where CMS has released what they believe stage two will be and are taking comments.

The proposed rule has a list of 49 measures that are all from NQF and they again are asking which are appropriate. Of course, there’s a lot of struggle around that. When we look at those measures, again there are many that do not seem to be appropriate for critical access hospitals.
One of the things I’m going to ask those people is what they wish they were being measured on, because clearly it doesn’t do any good to anybody to just report a bunch of zeroes, it’s basically a waste of time.

One of the thing’s that’s very funny is that there are two measures around ED throughput and they proclaim to have to do with patient and family engagement. Please hurry my sick person through the ER…then by doing it we will reduce that family concern…I don’t know, but each measure is grouped into one of these categories around vision family engagement, patient safety, care coordination, population and public health, efficient use of healthcare resources and clinical processes and effectiveness.

In the rule there’s a table you can look at. It is important that people look at these measures, say whether you think they are appropriate and if not and you have other measures that you wish were being reported, there is an opportunity to go on HealthIT.gov and put in your comments. You can also do this through your Reach rep and many ways through the state Department of Health to get those comments.

CMS actually changed stage one remarkably, based on comments so its something important to take time and do.

Here’s a link on table nine so you can look at the hospital measures and then, so the good news is that there is a very clear goal to begin to harmonize measures and in this table they actually say where the measure originated and then other measurement or requirement bodies that are also asking for this same measure.

Dr. Kevin Larson from Hennepin County is leading the choir. He has left there and gone to Washington to work actively on harmonization of quality measures both for the EH side but also for eligible providers, which again you can understand because in Minnesota a small provider shop is being driven absolutely crazy by the similar yet different measures that they’re being required to report on.

So there’s a big push to do this. We hope that by stage two the work will be effective, so the measures you’re doing for PQIS or IQR, whichever thing, would begin to be tightly aligned with the measures from meaningful use so you won’t only be measuring one thing.

One other interesting thing…there are requirements for clinical decisions that poor functionality to be turned on. Do you know what that is? Essentially it’s where the computer can look at the conditions of a patient or activity and then based on that use logic to either present a stop for the MD to say oh I shouldn’t do this or recommend a different behavior, encourage a test or whatever. That’s clinical decisions for computers who are really good at that.

In stage one there’s a requirement for just one clinical decision support rule to be turned on. It’s a loose requirement and CMS sort of stepped away from any attempt to define clinical decision support. In stage two this is pushed much further and there is language and guidance that says what we expect is that hospitals and eligible providers will use clinical decision support tools that are associated with clinical quality measures that they believe represent important outcomes for them.

So you have to have at least five CDS measures turned on and they should relate to again, if you’re going to have 24 measures maybe all of them won’t relate to a CDS but certainly they’re looking for some kind of linkage between the two, which is a very positive outcome.

I think you probably know this, you know how to get into the details of the measure, there are links here and resources on the final page along with many links so I want to encourage you to go there and go in to see the details of those measures and how you’re required to gather the data.
Again, with these measures it's sort of the job of your vendor of technology. You cannot go in and tweak the measures you can't. I'm not sure why we even show this to people because it's your vendors responsibility not yours. You may well be interested and know why you're getting such crazy numbers and you can look at it, but other than that.

Thanks for listening. Did this bring up any questions? No. Great.

I appreciate you being here and listening to my presentation.