Leveraging HITECH
Driving Clinical Performance

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Agenda

- Beyond stage 1
- Quality measures – retool or re-invent?

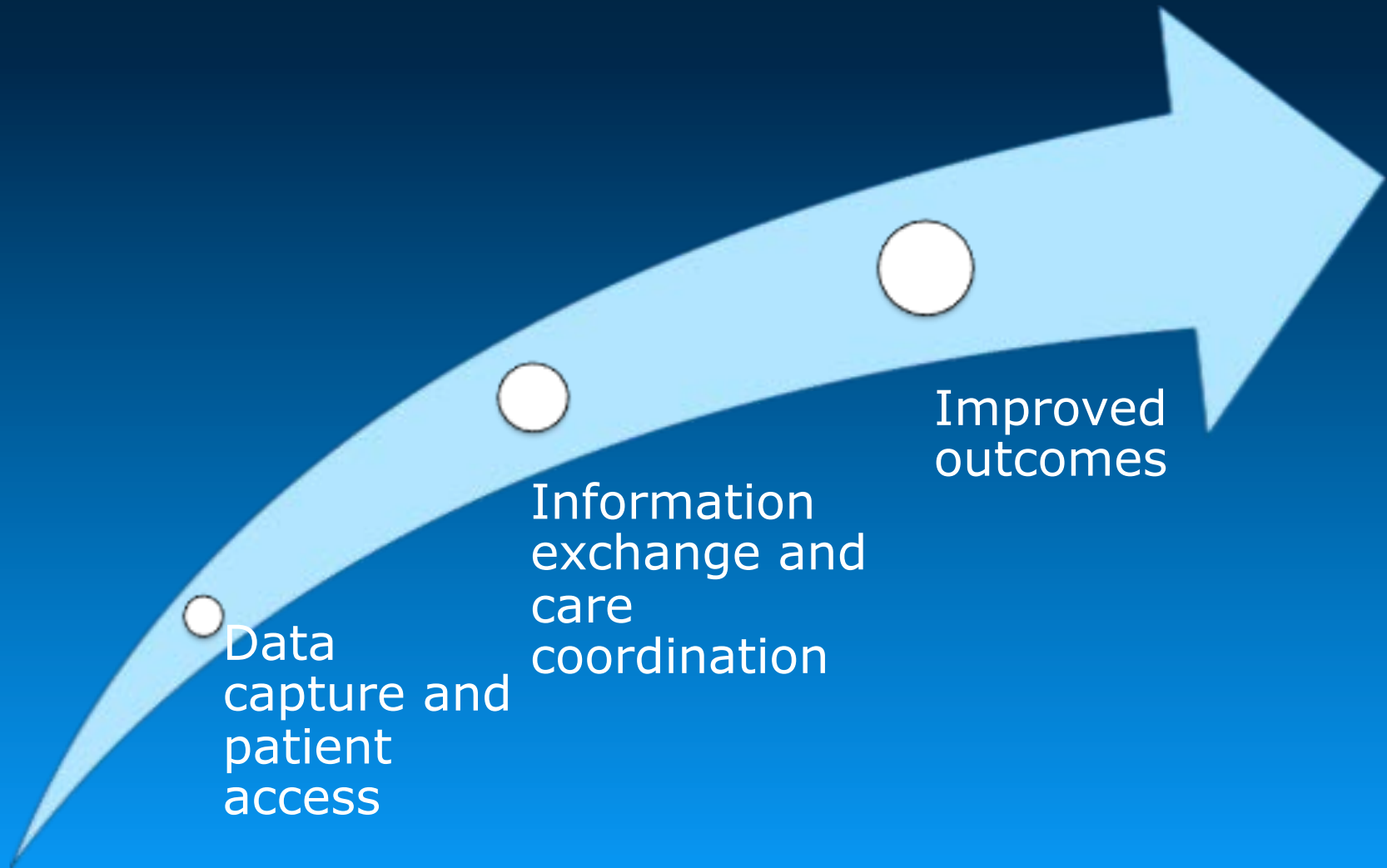# Meaningful Use is preparatory for health reform.

Better health
Better care
More affordable

Qualifying for EHR Incentives
Meaningful Use Components

- An eligible professional or hospital shall be a 'meaningful user' of the EHR if:
  - Uses a 'certified EHR'…
  - … in a 'meaningful manner' (including eRx)
  - … and exchanges health information to improve the quality of health care, such as promoting care coordination…
  - … and submits information on 'clinical quality measures'
- Requirements become 'more stringent' over time

Focus HIT on Health Priorities
Meaningful Use Categories

- Meaningful Use categories address key health goals:
  - Improve quality, safety, efficiency, & reduce disparities
  - Engage patients & their families
  - Improve care coordination
  - Improve population and public health
  - Ensure privacy and security protections

EARLY RETURNS
FOR STAGE 1

EHR Incentive Programs – Number of Providers Paid by Month, February 2012
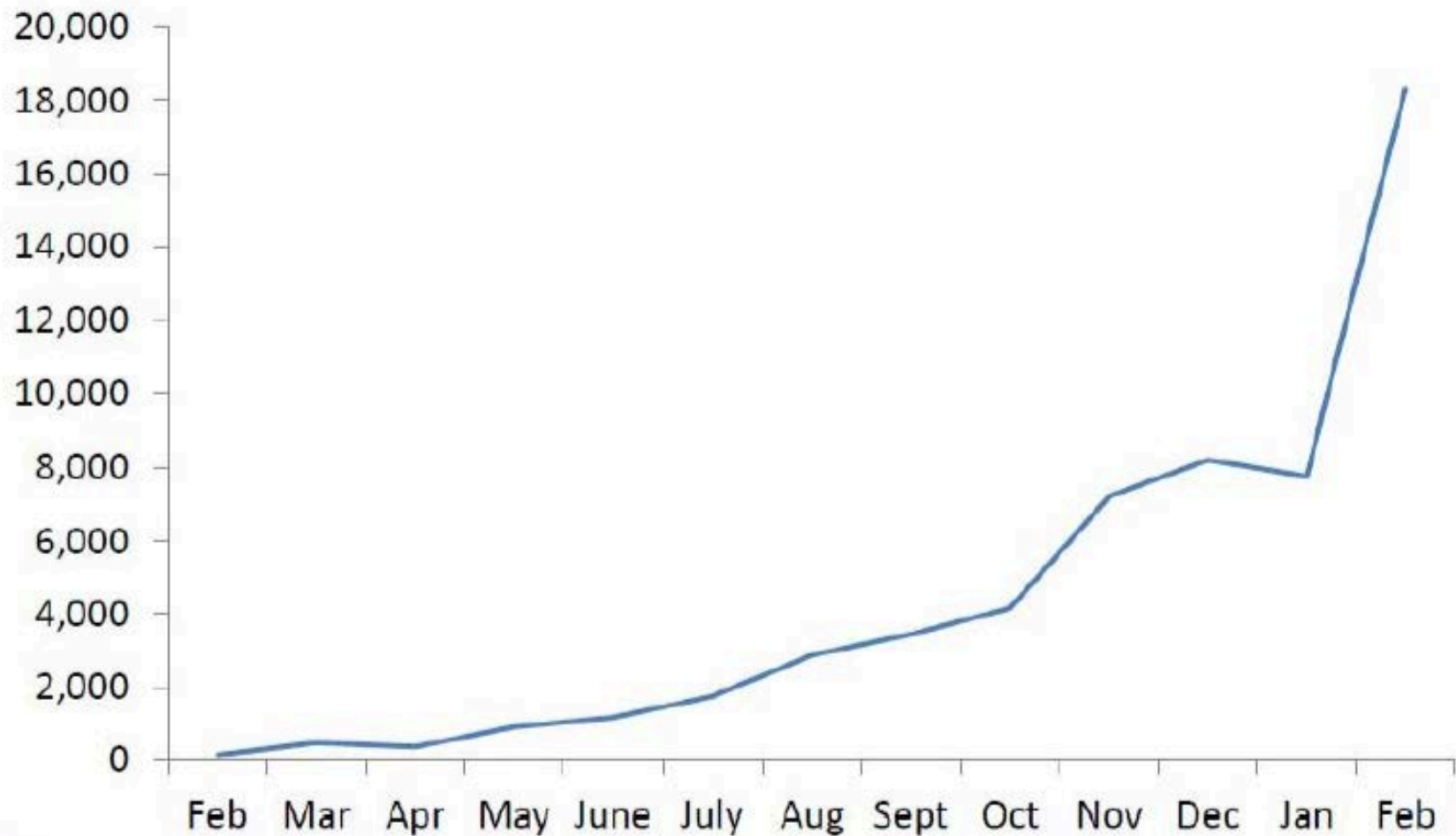
Active Registrations – May 2012

	May 2012	Program-to-Date
Medicare Eligible Professionals	**7,576**	**163,748**
Doctors of Medicine or Osteopathy	6,880	146,573
Dentists	12	224
Optometrists	331	7,236
Podiatrists	196	5,722
Chiropractors	157	3,993
Medicaid Eligible Professionals	**2,631**	**81,029**
Physicians	1,686	58,161
Certified Nurse-Midwives	38	1,728
Dentists	397	5,395
Nurse Practitioners	500	14,359
Physicians Assistants	10	1,386
Hospitals	**93**	**3,662**
Medicare Only	4	202
Medicaid Only	8	87
Medicare/Medicaid	81	3,373
Total	**10,300**	**248,439**

May – By the Numbers

- **48% of all eligible hospitals** have received an EHR incentive payment for either MU or AIU
  - 48% have made a financial commitment to put an EHR in place

- Approximately **1 out of every 5 Medicare and Medicaid EPs** have made a financial commitment to an EHR

- **57%** of Medicare EPs receiving incentives are specialists (non primary care)

Medicare & Medicaid Payments for June 2012
DRAFT ESTIMATES ONLY

Payments	May-12	LTD
Medicare EPs [ESTIMATED]	$65,000,000	$1,060,000,000
Medicaid EPs [ESTIMATED]	$105,000,000	$956,000,000
Medicaid/Medicare Hospitals (Medicare Pymt) [ESTIMATED]	$111,000,000	$1,997,000,000
Medicaid/Medicare Hospitals (Medicaid Pymt) [ESTIMATED]	$111,000,000	$1,948,000,000
Total	**$392,000,000**	**$5,961,000,000**

CMS' STAGE 2 NPRM

Impact Criteria

1. Supports new model of care (e.g., team-based, outcomes-oriented, population management)
2. Addresses national health priorities (e.g., NQS, Million Hearts)
3. Broad applicability (since MU is a floor)
   a. Provider specialties (e.g., primary care, specialty care)
   b. Patient health needs
   c. Areas of the country
4. Not "topped out" or not already driven by market forces
5. Mature standards widely adopted or could be widely adopted by 2016

MU Approach

- Exemplar
- Momentum

NPRM Stage 2 MU Updated Objectives
Improving Quality, Safety, Efficiency & Reducing Disparities

- Most stage 1 menu → core (except public health and AD)
  - Drug formulary
  - Structured clinical lab test results (55% of all orders)
  - Patient list (1+) with a specific condition
  - Clinical reminders (preventive/follow up) to 10% of active patients (seen within 24 mo prior to reporting period)
  - Patient-specific educational resources provided (>10%)
  - Med reconciliation (65% of transitions)
- New stage 2 menu items
- Enhance quality/safety
  - CPOE
    - Raise threshold of med CPOE to 30→60%
    - Add lab and radiology orders (60%)
  - Clinical decision support
    - Implement 5 CDS interventions related to 5+ clinical quality measures
  - EH: eMAR in use for >10% of med orders

NPRM Stage 2 MU Updated Objectives
Improving Quality, Safety, Efficiency & Reducing Disparities

- **EHR content**
  - Consolidated problems, meds, allergies → summary of care document
  - MENU: Record family history (≥1 1° relative) as structured data
  - Imaging results (40%) accessible through EHR (generally not stored in EHR)
  - MENU: Advance directive (record existence)
    - Hosp: 50% of 65yo+
- **Efficiency**
  - Hospital discharge eRx (10%)

NPRM Stage 2 MU Updated Objectives
Engaging Patients and Families

- **Access to information** (→ patient portal or PHR)
  - Provide ability to view, download, or transmit health information (>10% have done it)
    - EP: updated within 24 hrs of encounter (or $\leq$ 4d after available to EP)
    - Hospitals: updated within 36 hrs of discharge
  - EPs provide after-visit clinical summary for >50% of visits within 24 hrs

- **Secure online messaging** (EPs: >10% of patients seen initiate a message)

- Menu → core: Patient-specific educational resources provided (>10%)

NPRM Stage 2 MU Updated Objectives
Care Coordination

- **Summary of care record** (including **care plan goals and instructions** and **care team**) for **receiving provider** or post-acute facility**
  - Provide summary of care (>65% of transitions/referrals)
  - **Electronically transmit summary of care (>10%** of transitions/referrals) to **unaffiliated organization using EHR from different vendor**
- Menu → core: Med reconciliation (65% of transitions)

**Revised stage 1 menu option

NPRM Stage 2 MU Updated Objectives
Public and Population Health

- Ongoing submission to immunization registries
- EH: Ongoing submission of reportable lab results to public health
- Ongoing submission of syndromic surveillance data to public health agency
  - Menu for EP
  - Core for EH
- EP MENU: Ongoing submission to a registry
  - Cancer
  - Specialty

NPRM Stage 2 MU Updated Objectives
Privacy and Security

- Update security risk analysis and update security as needed
- Address encryption of data at rest

HIT Policy Committee MU Work Group
Timetable for MU Stage 2 and 3

- Late summer, 2012: Final Rule on stage 2

- Oct, 2012: HITPC preliminary recs on stage 3
- Nov, 2012: HITPC Request for Comments from public on draft stage 3 recommendations
- May, 2013: Final recommendations for stage 3 from HITPC to CMS and ONC

Going Beyond EHR Adoption:
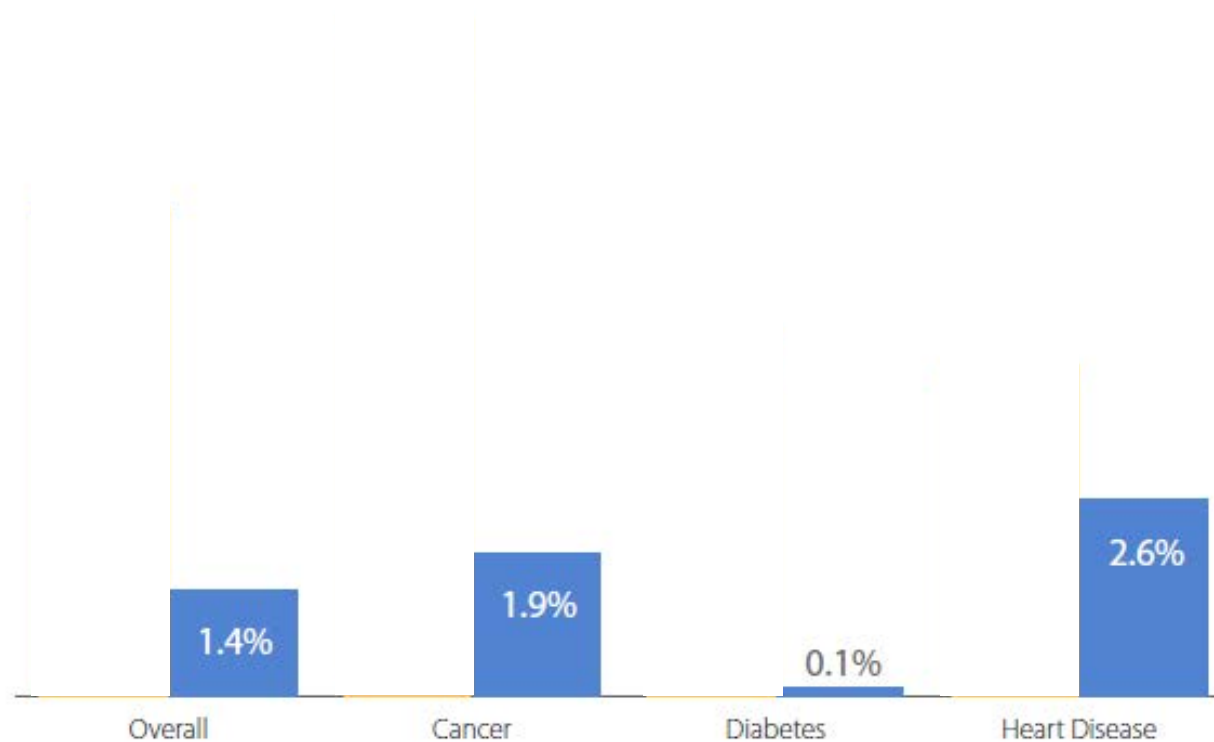## *Transforming Health Systems*

Using "Clinical Quality Measures" to Drive Clinical Performance

National Healthcare Quality Report

Change in Health Care Expenditures and Quality, United States, 2001–2005

Are we measuring the right things?

Deriving Quality Measures
US Historical Perspective

1. What data are available?
2. Which are standardized and combinable?
3. What important quality questions can you answer with the data you have?
4. What quality goals can you set based on the available data?

Impact of Using Administrative Data for Clinical Quality Reporting

Comparing Claims-Based Methods with EHR-Based Methods

Methods

- Randomly selected charts of Medicare patients reviewed for presence of diabetes by 3 methods
  - Gold standard chart review (to identify 125 diabetics)
  - Claims-based definitions used in CMS DOQ project
    (2 visits with encounter diagnosis of diabetes)
  - Query of coded information in EHR
    - Problem list, medication list, lab results (and not progress notes)
- Apply DOQ quality measures using standard definition vs. clinical definition

Results

- 98% of gold-standard diabetics identified using EHR coded data (sens=97.6%, spec=99.6%)
  - 94% identified using problem list alone
- 25% of gold-standard confirmed diabetics "missed" by *administrative claims-based* definition
- Statistically significant difference for 50% of diabetic performance measures when comparing those <u>identified</u> using administrative definition vs. those <u>missed</u> by administrative definition

Results
Performance Measure Differences in Subgroups

Table 5 ■ DOQ Diabetes Measures Calculated From Expert Review Data for all Patients Identified as Having Diabetes: Comparison of Patients With Two Visits for Diabetes Vs. Patients With Zero or One Visit

Measure (Probability, Fisher's Exact Test)	Zero or One Visit For Diabetes		Two visits For Diabetes	
	N (%)	D	N (%)	D*
DM1: HbA1c Management (p<.001)	21 (67.7%)	31	91 (96.8%)	94
DM2: HbAlc Management Control (measure of poor control) (p=0.27)	0 (0.0%)	21	6 (6.6%)	91
DM3: Blood Pressure Management (p=0.05)	14 (45.2%)	31	57 (60.6%)	94
DM4: Lipid Measurement (p=(0.06)	22 (71.0%)	31	78 (83.9%)	94
DM5: LDL Cholesterol Level (p=0.23)	21 (95.5%)	22	69 (88.5%)	78
DM6: Urine Protein Testing (p<.001)	17 (54.8%)	31	80 (85.1%)	94
DM7: Eye Exam (p=0.03)	12 (41.4%)	29	55 (61.8%)	89
DM8: Foot Exam (p=0.13)	2 (7.1%)	28	15 (16.5%)	91

Implications

Claims-Based Measures

- Underestimates target population (denominator)

- Biased toward spuriously higher scores (self-fulfilling prophesy)

- Potential to misdirect quality-improvement efforts

- Subject to "gaming" (no clinical downside)

EHR-Based Measures

- Accurately identifies target population (subject to policies)

- More accurate, though lower scores may disincent EHR adoption

- More accurate tool to manage clinical QI initiatives

- Clinical record less subject to "gaming" due to clinical reuse

Summary
HIT Policy Enables Health Reform

- $27B tail wagging the $2.8T/yr dog
- Raises the bar for EHR products
- Accelerates provider change
- Reshapes quality measures
- Care coordination, HIE, and new clinical quality measures are key to influencing MD decisions and to achieving health reform