

Consumer-Purchaser

**DISCLOSURE**

**PROJECT**

Improving Health Care Quality through Public Reporting of Performance

# **Meaningful Use of Health IT**

## **What Will Stage I Mean for Consumers and Purchasers**

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Informational Briefing

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# Agenda

## **Welcome and Introductions**

- Jennifer Eames Huff, PBGH

## **Overview of Meaningful Use Final Rule for Stage I**

- Christine Bechtel, NPWF

## **Advocacy Agenda and Next Steps**

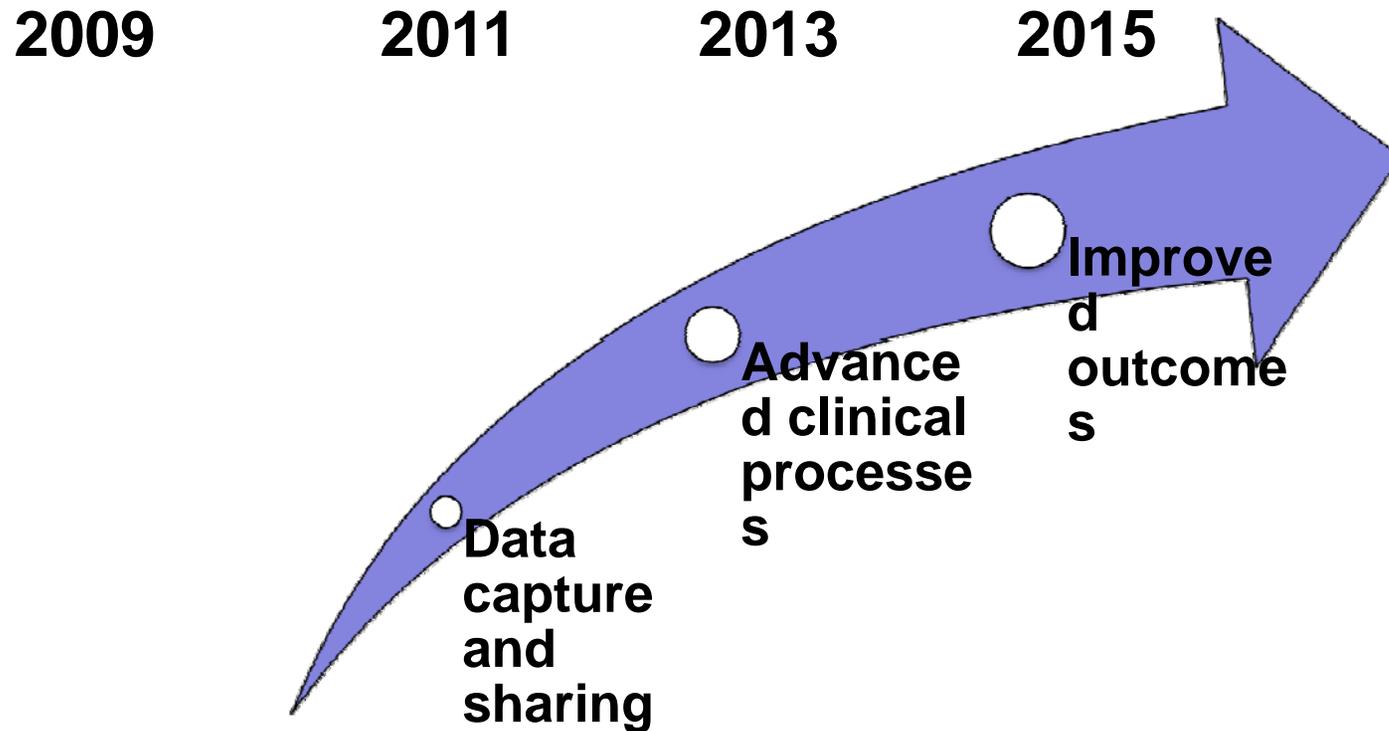
- David Lansky, PBGH
- Focus on prioritizing domains for advocacy activity

## **Q&A**

## Overview

- Meaningful Use Background
- Key Wins in 2011
- Summary of Key Elements
  - Objectives/Functional criteria
  - Quality metrics
- Disclosure Project's "Asks" vs. the Final Rule
- Areas for Improvement

# Staging of Meaningful Use Objectives



Source: Office of the National Coordinator (ONC)

# Structure of Incentive Payments

## Stage of Meaningful Use Criteria by Payment Year

First Payment Year	Payment Year				
	2011	2012	2013	2014	2015
					+**
2011	Stage 1	Stage 1	Stage 2	Stage 2	Stage 3
2012		Stage 1	Stage 1	Stage 2	Stage 3
2013			Stage 1	Stage 2	Stage 3
2014				Stage 1	Stage 3
2015					Stage 3

## Key Wins in 2011: MU Will Provide Foundation for Patient-Centered Delivery System

- Use of HIT to improve communication, care coordination, and patient access to their personal health information and educational resources
- Requires collection of quality data using EHR platform, including standardized RELG data
- Will offer patients and families tangible benefits in 2011, including summaries of office/hospital visits, and patient information.
- Sets the stage for making meaningful use requirements more rigorous in 2013, paving the way for greater innovation.

## Stage I Highlights

- 15 core objectives for Eligible Providers (EPs)
- 14 core objectives for Hospitals
- 10 optional, or “menu” objectives
  - Both hospitals and EPs must fulfill all core objectives and at least 5 menu objectives
- All fulfillment done via attestation
- Providers must choose at least one menu objective that address population/public health

## Core Objectives

- CPOE for medication orders
- Drug/drug and drug/allergy interaction checks
- E-prescribing (only applicable to EPs)
- Race, ethnicity, language, and gender (RELG) data collection
- Maintenance of problem list and medication list
- Vital Signs
- Smoking status
- 1 clinical decision support process
- Reporting of quality measures
- Provide electronic copy of health information to patients upon their request
- Provide e-copy of discharge/c instructions (upon request) and clinical office summaries to patients
- Test of data exchange between providers
- Security risk analysis

## Menu Objectives

- Drug Formulary checks
- Record advance directives (applies to hospitals only)
- Lab tests in EHR
- Generate lists of patients by specific conditions
- Reminders to patients
- Timely electronic access to health info for patients (EPs only)
- Patient-specific education resources
- Medication reconciliation
- Summary care record for care coordination
- Submission of electronic data to immunization registries
- Submission of electronic data on reportable lab results (hospital only)
- Submission of electronic syndromic surveillance data to public health agencies

## Changes Made for Flexibility/Achievement

- No “All or Nothing”: Core vs. Menu set
- Lowered required thresholds:
  - 80% if the objective relates to an existing standard; compliance is within provider’s control; and the objective relies solely on EHR capability. Examples:
    - Up-to-date problem list of current and active diagnoses
    - Maintain active medication list and medication allergy list
  - 50% if the objective is not within the provider’s control, there is no existing standard, but objective still relies solely on EHR capability. Examples:
    - Record patient demographics, vital signs, and smoking status
    - On request, provide patients with copy of health information
    - Within 3 days, provide patients with clinical summaries of office visit (EPs)

## MU and Quality Metrics

- Establishing a Digital Platform for Performance Data Collection
- Providers will report e-enabled quality measures
  - **2011**: Compliance through attestation of aggregate numerator and denominator data.
  - **2012**: Expect electronic submission of data

## Quality Measurement by Eligible Providers

EPs required to submit quality data on six measures:

### 3 core measures:

1. Hypertension: Blood Pressure Measurement
2. Tobacco Use Assessment and Tobacco Cessation Intervention
3. Adult Weight Screening and Follow-up
  - Alternate core measures: influenza screening (age 50+), child and adolescent weight assessment, child immunization status

### +3 out of a menu of 38 optional measures

- Measures focus on high priority conditions (high cost, high prevalence)
  - Some alignment with Physician Quality Reporting Initiative (PQRI) measures

## Quality Measurement for Hospitals

- Hospitals required to attest to data on 15 quality measures
  - No alignment with “Reporting Hospital Quality Data for Annual Payment Update (RHQDAPU)” program
    - Avoid redundant/duplicative reporting
    - Anticipation of a single set of e-specified hospital quality measures in the future
  - Measures include
    - 2 ED Throughput
    - 7 Stroke
    - 4 VTE-related
    - 2 platelet/anticoagulant monitoring

*How did the consumer-purchaser  
advocacy agenda fare?*

David Lansky, PhD

## Consumer-Purchaser Comments to CMS vs. Final Rule

- *Retain the concept of a core measure set in 2011, but for future years replace the proposed measures with ones that are more meaningful to consumers and purchasers.*
- Response:
  - Drug avoidance in the elderly measure replaced by adult weight screening. Blood pressure and tobacco cessation remain.
  - Core measures applicable to all relevant specialties. Alternate set of core measures available to specialties who have zero patients in the denominator for the standard core set.

## Consumer/Purchaser Comments and Responses

- *Follow the recommendation of the HIT Policy Committee and make it a requirement that providers measure efficiency, by*
  - *1) recording the rate of prescribing of generics; and 2) collecting data on high cost imaging services being prescribed.*
- Response: Efficiency measures not included in Stage 1 Final Rule.

## Consumer/Purchaser Comments and Responses

- *Reinstate Advance Directives in EHRs*
  - Response: Advance Directive recording included as a menu option, but only for hospitals
- *Require providers to use EHR technology to offer patients educational materials whenever available*
  - Response: Included as a menu option for both hospitals and EPs
    - Threshold is 10% of patients.

## Consumer/Purchaser Comments and Responses

- *Collect and use data on race, ethnicity, language and gender for all patients.*
- Response
  - Collection of demographic data (including RELG) is a core objective;
    - Threshold: 50% of patients
  - Generating lists of patients by condition is a menu objective:
    - Providers not required to stratify those lists by RELG,
    - Providers not required to use RELG data to stratify quality metrics, reports generated for patient outreach, or other quality initiatives

# **Taking Meaningful Use Further: Prioritizing Advocacy Goals for 2013**

## Areas for Improvement in Future Stages

- Office of the National Coordinator (ONC), CMS, National Quality Forum, and other stakeholders are already looking ahead to 2013 in various areas:
  - Expanding quality measure requirements
  - Strengthening and expanding the objectives and functional criteria

## Gaps in Stage 1 Objectives That Must be Addressed

- Use, not just collection, of RELG
- Significant strengthening of patient experience/communication/care coordination objectives
  - Require more patients receive electronic copy of their health information in a shorter time frame
  - Require providers to give patients electronic copy of discharge/clinical summary, not just upon request
  - Make electronic access to health information a core objective (currently a menu objective)
  - Set threshold for providing patients with patient-specific education resources higher than 10%, and make it a core objective

## Gaps in Objectives, continued

- Require not just implementation of CPOE and clinical decision support tools, but also require that their effects be monitored ensure that it is being used as intended, and improving patient safety rather than potentially causing harm.
- Require measures that identify whether resources are being used efficiently
- Require additional tests of providers' ability to exchange data with other specialists (currently, core objective but only 1 test of exchange capability is required)
- Add administrative simplification measures to the core objective set.
- Expand the patient-engagement and patient education objectives to include shared decision-making tools.

## Gaps in Quality Measurement

- Focus on measures that reflect outcomes, including mortality, morbidity, Healthcare-acquired Conditions (HACs), readmissions, functional status, patient experience of care, care coordination, care transitions, and efficiency.
- Use the following criteria to assess meaningful measures for 2013 and beyond:
  - Have a high impact on how care is delivered
  - Address gaps previously identified in both PQRI and RHQDAPU
  - Relevant to consumers and purchasers
  - Reflect the continuum of care and encourage care coordination
  - Address appropriateness of care
  - Allow for assessing and reporting on disparities
- Determine – from the measures that satisfy the above criteria – whether they reflect issues/processes/outcomes that could be improved if enabled by HIT (i.e. processes that relate to team based care and care coordination).

## Immediate Opportunities to Get Involved

- September 2010: ONC's HIT Policy Committee preliminary discussions on quality measures for 2013
- November/December, 2010: Request for Input on 2013 and 2015 released
- March-June, 2011: Final recommendations made to ONC

## How Can We Shape Meaningful Use to Drive Value in 2013 and 2015?

Examples of HIT-driven domains where stronger requirements are needed:

- Patient Engagement, Care Coordination, and Safety
  - Portability and accessibility of health information
  - Increase patient engagement in decision-making and evaluation
  - Coordinate and assess care across the continuum
  - Increase evidence-based care through decision support
- Quality, Efficiency, and Public Reporting
  - Assess specialists' performance
  - Public recognition and reporting of quality performance
  - Measure the efficient and appropriate use of resources
- Simplification of Administrative Transactions

## Additional Resources

- [The “Meaningful Use” Regulation for Electronic Health Records](#), David Blumenthal, M.D., M.P.P., and Marilyn Tavenner, R.N., M.H.A., New England Journal of Medicine, August 5, 2010.
- [Meaningful Use Final Rule: Preliminary Analysis](#), National Partnership for Women & Families and Consumer Partnership for e-Health, July 2010.
- [Centers for Medicare and Medicaid Services \(CMS\)](#), summary and information on meaningful use.

## About the Disclosure Project

The Consumer-Purchaser Disclosure Project is an initiative that is improving health care quality and affordability by advancing public reporting of provider performance information so it can be used for improvement, consumer choice, and as part of payment reform. The Project is a collaboration of leading national and local employer, consumer, and labor organizations whose shared vision is for Americans to be able to select hospitals, physicians, and treatments based on nationally standardized measures for clinical quality, consumer experience, equity, and efficiency. The Project is funded by the Robert Wood Johnson Foundation along with support from participating organizations.

*Previous Discussion Forums and briefings are available at: <http://healthcaredisclosure.org/activities/>*

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