The New eMeasure Specifications' Impact on Data Capture and Workflow

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June 2016

APRIL 2016 ECQM UPDATES

Medicare, Medicaid, and commercial payers are all striving to move to reimbursing providers based on value rather than volume. The Centers for Medicare and Medicaid Services (CMS) developed the CMS Quality Strategy, which lays out a specific plan to shift reimbursement from fee-for-service to value-based reimbursement. As this shift continues, electronic clinical quality measures (eCQMs) become increasingly important, as they will become the mechanism to demonstrate this "value." Most organizations have focused on abstracted clinical quality measures and their measure performance in the past, treating eCQMs solely as a "check-the-box" activity.

In 2016, the Hospital Inpatient Quality Reporting (IQR) Program made a significant shift, requiring a small number of eCQMs to be submitted electronically, in addition to their abstracted version. CMS has proposed to require the electronic submission of eCQMs in CY 2017 for the Hospital IQR program, but it is proposed to remain optional for the Meaningful Use (MU) program.[1] The accelerating focus on value uses eCQMs as the vehicle, requiring organizations to understand, monitor, and improve their eCQM measure performance. Each year, new measure specifications are released. These new measure specifications must be reviewed, and the impact on data capture and workflow must be identified and addressed to ensure accurate measure results.

The annual update of eCQM specification updates for the 2014 Clinical Quality Measures was published on April 6, 2016. This update included changes to 29 Eligible Hospital (EH) measures and 64 Eligible Professional (EP) measure specifications. Electronic reporting of CQMs for MU and other quality reporting programs, such as Hospital IQR or the Merit-based Incentive Payment System (MIPS), will require the use of these updated measure specifications beginning in January 2017. As some of the changes to eCQM definitions will require new or modified data definitions, organizations need to understand what workflow changes are needed in their CEHRT to ensure accurate measure calculation in the new reporting year.

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First, CMS is proposing to reduce the number of EH eCQMs from 29 to 16, some of which may not have previously been in scope for a given organization. If they were not supported previously, these measures will require evaluation of the CEHRT build, data capture, clinical workflows, and clinician adoption to determine any issues with "new" measures – all in time for data collection beginning on January 1, 2017. The 16 remaining measures proposed are:

- AMI-8a: Primary PCI Received Within 90 Minutes of Hospital Arrival
- ED-1: Median Time from ED Arrival to ED Departure for Admitted ED Patients
- ED-2: Admit Decision Time to ED Departure Time for Admitted Patients
- ED-3: Median Time from ED Arrival to ED Departure for Discharged ED Patients[2]

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[1] The FY 2017 Inpatient Prospective Payment System (IPPS) Proposed Rule was released on April 18, 2016. The FY 2017 IPPS Final Rule is expected to be released in early-August 2016. This rule will finalize any changes to eCQM reporting and electronic submission for both the IQR and MU programs.

[2] ED-3 is included only for attestation in the MU program. As an outpatient measure, it is not included in the Hospital IQR program, and therefore cannot be submitted electronically through QualityNet.

- EHDI-1a: Hearing Screening Prior to Hospital Discharge
- HMPC: Home Management Plan of Care Document Given to Patient/Caregiver
- PC-01: Elective Delivery
- PC-05: Exclusive Breast Milk Feeding
- STK-2: Discharged on Antithrombotic Therapy
- STK-3: Anticoagulation Therapy for Atrial Fibrillation/Flutter
- STK-5: Antithrombotic Therapy by the End of Hospital Day 2
- STK-6: Discharged on Statin Medication
- STK-8: Stroke Education
- STK-10: Assessed for Rehabilitation
- VTE-1: Venous Thromboembolism Prophylaxis
- VTE-2: Intensive Care Unit Venous Thromboembolism Prophylaxis

For the 13 measures CMS has proposed to remove from the program, some organizations may choose to continue tracking them for internal reporting purposes. There are changes to these measure definitions, but since these 13 measures have either been deemed "topped out" or have feasibility issues with electronic implementation, we have not focused on them in this analysis. If an organization chooses to continue reporting on these measures, we recommend a careful analysis of the definition changes to determine what CEHRT and/or workflow changes will be required to ensure consistent, accurate capture of the data needed to support these measures. Organizations should also check with their CEHRT vendor(s) to determine if the vendor(s) will continue to support these discontinued measures.

Of the remaining 16 eCQMs, there are seven measures with changes that will likely require modifications to workflow to ensure the accurate, complete, and consistent capture of the data required. Detailed below are potential areas in the updated eCQM definitions that organizations should review. If the specified data is not captured as required by the eCQM definition, organizations should begin planning for, remediating, and implementing the necessary CEHRT and/or workflow changes immediately. Organizations should also plan for time post-implementation to address workforce adoption of these new workflows. These changes should be operational by January 1, 2017, to ensure accurate reporting of results from the beginning of the reporting period.

- AMI-8a: Primary PCI Received Within 90 Minutes of Hospital Arrival

- Electrocardiogram (ECG) results must be captured in a structured format (i.e., not just reflected in narrative notes) for accurate denominator calculation.
    - » If a timely Percutaneous Coronary Intervention (PCI) procedure is not performed, structured data capture of the reason is required.
    - » Both admit source and arrival time must be accurate and in a structured format, including "transfer from another facility."

- ED-1: Median Time from ED Arrival to ED Departure for Admitted ED Patients
    - » Both admit source and arrival time must be accurate and in a structured format, including "transfer from another facility."

- ED-2: Admit Decision Time to ED Departure Time for Admitted Patients
    - » Both admit source and arrival time must be accurate and in a structured format, including "transfer from another facility."

- EHDI-1a: Hearing Screening Prior to Hospital Discharge
    - » Requires the structured data capture of hearing screen results for each ear.
    - » If no hearing screen was completed for each ear, structured data capture of the reason is required.

- HMPC: Home Management Plan of Care Document Given to Patient / Caregiver
    - » Requires the structured capture of the provision of the HMPC document.
    - » If no HMPC document is provided, structured capture of the reason is required.

- PC-01: Elective Delivery
    - » Requires the structured capture of mother's gestational age at time of delivery on the mother's record.
    - » Requires the structured capture of labor start on the mother's record.

- PC-05: Exclusive Breast Milk Feeding

  » Requires the structured capture of baby's gestational age at time of delivery on the baby's record.

  » Requires the structured capture of every feeding substance (e.g., breast milk, formula) on the baby's record.

Encore advises that organizations review the proposed changes for all 16 measures to ensure data required to calculate the measures is captured accurately and consistently in the CEHRT; however, if an organization has been diligent in monitoring eCQMs – despite previously only having to attest to their results – the above changes are likely the only areas requiring attention.

In addition to these specific measure definition changes, a few other broader changes have been made to the technical reporting requirements related to diagnoses and principal procedures. The concept of "status" has been removed from the reporting requirements; alternatively, "active" is now inferred by the absence of an abatement (i.e., end) date/time, while "inactive" or "resolved" diagnoses would have an abatement date/time present. Related to principal procedure, this is generally the procedure that is chosen post-discharge and is set as the principal procedure during the coding process. All dates/times associated with this principal procedure should reflect the actual dates/times of the procedure, including start and end date/time, as well as incision date/time.

ELIGIBLE PROFESSIONALS

Changes to the 64 EP measures may have some impact on workflow, depending on the measures an organization chooses to report. To ensure the accurate, complete, and consistent capture of the required data, we recommend providers carefully analyze the measures selected for reporting to determine the extent of workflow or data capture change required.

Important items for consideration regarding these EP measures include:

- CMS 136: ADHD: Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication
  - » Measure logic change to include a 300-day constraint for limiting the cumulative medication duration in the Initial Population. The addition of this constraint to the logic aligns the population with the measure intent. Previous versions of the measure did not include this constraint, allowing the cumulative medication duration to be calculated for an unrestricted timeframe.
  - » Current measure definition allows the office visit where the initial prescription was written to also count as a follow-up visit.

- Three measures are no longer endorsed by the National Quality Forum (NQF). As such, providers may choose to no longer report on these measures. They are:
  - » CMS 126: Use of Appropriate Medications for Asthma
  - » CMS 146: Appropriate Testing for Children with Pharyngitis
  - » CMS 148: Hemoglobin A1c Test for Pediatric Patients

In conducting a deep dive analysis of 18 EP measures, the subset of 6 measures below provides an example of some potential challenges that could impact workflow and reporting results. Note that several of these measures require data that is typically captured outside of the standard clinical workflow. Providers should expect inaccurate or incomplete results if workflow remediation is not completed to support structured, electronic capture of the required data.

- CMS 69: Preventive Care and Screening: BMI Screening and Follow-Up Plan
  - » In addition to the structured capture of the body mass index (BMI) result, a structured reason concluding a patient is overweight or underweight must be documented as a reason for ordering follow-up care or appropriate medications.

- CMS 75: Children Who Have Dental Decay or Cavities
  - » Requires the presence of any dental caries to be documented as a diagnosis. Structured documentation of the finding is not acceptable for this measure.

- CMS 117: Childhood Immunization Status

  » Requires a "seropositive" laboratory test result to be documented as structured data. The result of the test is often numeric, and the seropositive description is often embedded in the laboratory interpretation report, making it difficult to translate what is documented in the CEHRT to the required value set for reporting.

- CMS 126: Use of Appropriate Medications for Asthma

  » Medication value set does not contain all forms of appropriate asthma medications, possibly reducing the numerator result, even when appropriate asthma medications are prescribed.

- CMS 138: Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention

  » Limited Life Expectancy as a reason for not completing the tobacco use screening is now required to be documented as a diagnosis. If this data was previously captured as a diagnosis, no workflow change will be required. However, if this data was previously documented as a structured reason for no tobacco use screening, a workflow change is required to code and capture this data as a diagnosis.

- CMS 153: Chlamydia Screening for Women

  » Logic statements added into denominator exclusion do not align logic with measure intent as stated. Encore is seeking clarification of this new logic from the Office of the National Coordinator for Health Information Technology (ONC).

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