December CMS and ONC eHealth Vendor Workgroup

December 17, 2015
12:00 PM EDT

Agenda Item	Speaker
eCQM Submission Deadline Extension Reminder	Stephanie Wilson *Health Services Advisory Group on behalf of CMS*
Hybrid Measures for EH Reporting Update	Megan Hayden *CMS' Office of Clinical Standards and Quality*
The Joint Commission Update	Patty Craig *The Joint Commission*
New and Updated Resources for Participation in the Medicare and Medicaid EHR Incentive Programs in 2015	Beth Myers *CMS' Office of Clinical Standards and Quality*
Questions	

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Stephanie Wilson

ECQM SUBMISSION DEADLINE EXTENSION REMINDER

Hospital Inpatient Quality Reporting (IQR) Program Update

Stephanie Wilson, MBL
Project Lead, IQR-EHR Alignment (formerly eCQM)
Inpatient Value, Incentives, and Quality Reporting (VIQR)
Outreach and Education Support Contractor (SC)

December 17, 2015

eCQM Submission Deadline Extension

- The reporting deadline has been extended to **December 30, 2015** for hospitals that chose to:
  - Voluntarily report eCQMs for the Hospital IQR Program
  - e-Report eCQM data for the Medicare EHR Incentive Program
- Data must be submitted via the *QualityNet Secure Portal*

Note: *The Medicare EHR Incentive Program attestation deadline for calendar year 2015 is still* ***February 29, 2016****. It has not been affected by this change.*

How to Get Involved

CMS strongly encourages vendors and hospitals to continue working toward the successful submission of eCQM data by:

- Submitting test files through the CMS eCQM Receiving System (*QualityNet Secure Portal*)
- Signing-up for the Hospital Reporting EHR ListServe and participating in training opportunities at: www.qualitynet.org/dcs/ContentServer?pagename=QnetPublic/ListServe/Register

Thank You!

- **Stephanie Wilson – IQR eCQM Program Support**
  - stephanie.wilson@area-m.hcqis.org
- **eCQM General Program Questions**
  - https://cms-ip.custhelp.com
  - 866.800.8765 or 844.472.4477, 7 a.m.–7 p.m. CT Monday–Friday (except holidays)

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Megan Hayden

HYBRID MEASURES FOR EH REPORTING UPDATE

Core Clinical Data Elements

Megan Hayden, RN, MSN
Nurse Consultant
Centers for Medicare &Medicaid Services (CMS)

December 17, 2015

Core Clinical Data Elements

- Core Clinical Data Elements (CCDEs) were developed in an approach to collect an accurate assessment of services provided by clinicians and hospitals.
- Enriched clinical data from an Electronic Health Record (EHR) system are being utilized to supplement the clinically limited datasets available from administrative claims data.

What are CCDEs? How are they Used?

- A set of 21 core clinical data elements have been identified that are:
  - Routinely collected on hospitalized adults
  - Feasibly extracted from hospital EHRs
  - Relevant to patient outcomes following hospitalization
- Testing has shown that these can be used to risk adjust 30-day mortality and 30-day readmission outcome measures

Core Clinical Data Elements

Patient Characteristics/First-Captured Vital Signs

Currently Identified CCDEs Considered for Risk-Adjustment of Hybrid Outcome Measures Used in the Hospital Setting		
Data Elements	**Units of Measure**	**Time Window for First Captured Values**
Patient Characteristics		
Age at Admission	Years	---
Gender	Male or Female	---
First-Captured Vital Signs		
Heart Rate	Beats per Minute	0–2 hours
Systolic Blood Pressure	mmHg	0–2 hours
Diastolic Blood Pressure	mmHg	0–2 hours
Respiratory Rate	Breath per Minute	0–2 hours
Temperature	Degrees Fahrenheit	0–2 hours
Oxygen Saturation	Percent	0–2 hours
Weight	Pounds	0ıı24 hours

Core Clinical Data Elements

First Captured Laboratory Results

Currently Identified CCDEs Considered for Risk-Adjustment of Hybrid Outcome Measures Used in the Hospital setting		
Data Elements	**Units of Measure**	**Time Window for First Captured Values**
First Captured Laboratory Results		
Hemoglobin	g/dL	0–24 hours
Hematocrit	% red blood cells	0–24 hours
Platelet	Count	0–24 hours
WBC Count	mEq/L	0–24 hours
Potassium	mEq/L	0–24 hours
Sodium	mEq/L	0–24 hours
Chloride	mEq/L	0–24 hours
Bicarbonate	Mmol/L	0–24 hours
BUN	mg/dL	0–24 hours
Creatinine	mg/dL	0–24 hours
Glucose	mg/dL	0–24 hours
Troponin	ng/mL	0–24 hours

Capturing the First Value of the CCDE

- Logic for the CCDE is built with a 24-hour “look back” period.
- From the start of the inpatient admission, look back 24-hours and gather the **first** recorded value for each of the CCDEs.
- If there is no data in the 24-hour look-back period, use the start of the inpatient admission to gather CCDE values.

Numerator Logic

AND:

OR: First: "Physical Exam, Performed: Heart rate” satisfies all:

- (result)
- <= 1440 minute(s) starts before start of Occurrence A of Encounter, Performed: Inpatient encounter CCDE (facility location arrival datetime)

OR: First: "Physical Exam, Performed: Heart rate” satisfies all:

- (result)
- <= 120 minute(s) starts after start of Occurrence A of Encounter, Performed: Inpatient encounter CCDE (facility location arrival datetime)

Hybrid Measures

- Hybrid measures are quality measures that utilize more than one source of data to determine outcomes.
- Envision utilizing CCDE in conjunction with other sources of data, such as administrative claims, to calculate “hybrid” outcome measures.
- Enhance the current CMS administrative claims-based outcome measures by utilizing patient clinical data captured in the EHR.

Hybrid Measures

Two hybrid measures have been developed which illustrate the use of the 21 core clinical data elements:

- The Hospital 30-day Risk-Standardized Acute Myocardial Infarction (AMI) Mortality eMeasure
- The Hospital-wide 30-day readmission eMeasure (this measure has not yet undergone National Quality Forum (NQF) endorsement proceedings)

CCDE Submission Methods

CMS would use Quality Reporting Document Architecture (QRDA) Category I standards as submission options for CCDE in order to:

- Enhance further alignment across CMS programs
- Reduce EHR developer and provider burden by adopting standards that are already in place

Polling Question 1

Are the 21 data elements listed previously routinely captured in EHR systems as structured data that can be used in reporting?

- ❑ Yes 79.17%
- ❑ No 20.83%

Polling Question 2

How often would you suggest this data should be submitted to CMS?

- ❑ Monthly 4%
- ❑ Quarterly 52%
- ❑ Once per year 44%

Polling Question 3

Would you recommend utilizing QRDA Cat I files to report this data?

- ❑ Yes 90.9%
- ❑ No 9.09%

Polling Question 4

Would you be interested in participating in a pilot to test submission of this data to CMS?

- ❑ Yes 33.3%
- ❑ No 66.7%

CCDE Pilot Participation Opportunity

- For those that may be interested in participating in a CCDE Pilot, please send an email to Stephanie Wilson at stephanie.wilson@area-M.hcqis.org
- Please include your name and contact information in the email and use “CCDE Pilot” in the subject line.

For CCDE Inquiries

E-mail:

ccde@mathematica-mpr.com

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Patty Craig

THE JOINT COMMISSION

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Beth Myers

NEW AND UPDATED RESOURCES FOR PARTICIPATION IN THE MEDICARE AND MEDICAID EHR INCENTIVE PROGRAMS IN 2015

CMS Releases New Resources on the EHR Incentive Programs

Visit the EHR Incentive Programs Website to review the following materials:

- Eligible Professionals and Eligible Hospitals/CAHs: What You Need to Know for 2015
- Overview of the EHR Incentive Programs in 2015-2017
- What's Changed for the EHR Incentive Programs in 2015-2017
- Eligible Professionals and Eligible Hospitals/CAHs Attestation Worksheets
- Alternate Exclusions and Specifications Fact Sheet
- Eligible Professionals and Eligible Hospitals/CAHs Objectives & Measures Tables
- Eligible Professionals and Eligible Hospitals/CAHs Specification Sheets

CMS will continue to update the EHR Incentive Programs website to include additional information and resources for eligible professionals and eligible hospitals/CAHs. Stay tuned!

CMS Clarifies Important Information for 2015 Participation in the EHR Incentive Programs

To ensure that providers can successfully attest to the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs, updates have been made to the following objectives:

- For Objective 1, it is acceptable for the security risk analysis to **Protect Patient Health Information** to be conducted outside the EHR reporting period; however, the analysis must be unique for each EHR reporting period, the scope must include the full EHR reporting period, and the analysis or review must be conducted prior to the date of attestation. (See FAQ13649 for the Security Risk Analysis)

- For Objective 5, the **Health Information Exchange** may occur before, during, or after the EHR reporting period but the action must take place no earlier than the start of the same calendar year as the EHR reporting period and no later than the date of attestation. For eligible hospitals and CAHs, the action must take place no earlier than the beginning of the federal fiscal year (October 1, 2014) and no later than the date of attestation.

- For Objective 6, eligible professionals may perform the **Patient Specific Education** action before, during, or after the EHR reporting period but no earlier than the start of the same calendar year as the EHR reporting period and no later than the date of attestation. While, the action for eligible hospitals/CAHs may reasonably fall outside the EHR reporting period timeframe but the numerator must include the qualifier "subsequently," indicating that the patient-specific education resources were be provided after the patient's admission to the hospital and no later than the date of attestation.

- For Objective 8, the patient may **view, download, and transmit** their health information before, during, or after the EHR reporting period but no earlier than the start of the same calendar year as the EHR reporting period and no later than the date of attestation. For eligible hospitals and CAHs, the action must take place no earlier than the beginning of the federal fiscal year (October 1, 2014) and no later than the date of attestation.

Please note: *In the final rule, CMS clarified the calculations for these objectives and noted that some certified EHR systems may include variation in how the actions are calculated. CMS will not require developers to modify those calculations for the 2014 Edition and providers may use the calculation included in their CEHRT for reporting in 2015 (80 FR 62792).*

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NEW AND UPDATED FREQUENTLY ASKED QUESTIONS (FAQS)

FAQ 8231

Question: While the denominator for measures used to calculate meaningful use in the Medicare and Medicaid Electronic Health Records (EHR) Incentive Programs is restricted to patients seen during the EHR reporting period, is the numerator also restricted to activity during the EHR reporting period or can actions for certain meaningful use measures be counted in the numerator if they took place after the EHR reporting period has ended?

Answer: The criteria for a numerator is not constrained to the EHR reporting period unless expressly stated in the numerator statement for a given meaningful measure. The numerator for the following meaningful use measures should include only actions that take place within the EHR reporting period: Preventive Care (Patient Reminders) and Secure Electronic Messaging.

For all other meaningful use measures, the actions may reasonably fall outside the EHR reporting period timeframe but must take place no earlier than the start of the reporting year and no later than the date of attestation in order for the patients to be counted in the numerator, unless a longer look-back period is specifically indicated for the objective or measure.

For program year 2015 and subsequent years, the requirements have been defined in the final rule (80 FR 62792)

For information specific to the Security Risk Assessment in 2015 and subsequent years, see FAQ #13649 https://questions.cms.gov/faq.php?faqId=13649&id=5005

Link to FAQ: https://questions.cms.gov/faq.php?faqId=8231&id=5005

FAQ 13649

Question: For Objective 1: Protect Patient Health Information (ePHI), can the security risk analysis or review take place outside the EHR reporting period?

Answer: Yes, it is acceptable for the security risk analysis to be conducted outside the EHR reporting period; however, the analysis must be conducted for the certified EHR technology used during the EHR reporting period and the analysis or review must be conducted on an annual basis.

In other words, the provider must conduct a unique analysis or review applicable for the EHR reporting period and the scope of the analysis or review must include the full EHR reporting period.

The analysis or review for the EHR reporting period must be conducted prior to the date of attestation.

Link to FAQ: https://questions.cms.gov/faq.php?faqId=13649&id=5005

FAQ 13653

Question: What can count as a specialized registry?

Answer: In order to count as a specialized registry, a receiving entity needs to declare that they are ready to accept data as a specialized registry and be using the data to improve population health outcomes.

- The receiving entity must be able to receive electronic data generated from CEHRT; manual data entry into a web portal would not qualify for submission to a specialized registry.
- The electronic file can be sent to the receiving entity through any appropriately secure mechanism including, but not limited to, a secure upload function on a web portal, sFTP, or Direct.
- The receiving entity must also be able to support documentation related to the submitting provider's Active Engagement status.
- The receiving entity should have a registration of intent process, a process to take the provider through test and validation and a process to move into production.
- The receiving entity should be able to provide appropriate documentation for the sending provider or their current status in Active Engagement.
- Consistent with existing policy, an action to meet one program requirement may not count toward meeting another objective or requirement. Therefore, the sending provider cannot meet the measure using a submission of data already being sent to meet other EHR Incentive Program requirements, such as using a QCDR to submit eCQMs to CMS to meet quality reporting requirements.

Link to FAQ: https://questions.cms.gov/faq.php?faqId=13653&id=5005

FAQ 13657

Question: What steps does a provider have to take to determine if there is a specialized registry available for them, or if they should instead claim an exclusion?

Answer: The provider is not required to make an exhaustive search of all potential registries. Instead, they must do a few steps to meet due diligence in determining if there is a registry available for them, or if they meet the exclusion criteria.

1. A provider should check with their State to determine if there is an available specialized registry maintained by a public health agency
2. A provider should check with any specialty society with which they are affiliated to determine if the society maintains or endorses a specialized registry

If the provider determines no registries are available, they may exclude from the measure.

PLEASE NOTE: In 2015, providers may also simply claim an alternate exclusion for a measure as defined in FAQ 12985 https://questions.cms.gov/faq.php?faqId=12985&id=5005

To review the full FAQ, visit: https://questions.cms.gov/faq.php?faqId=13657&id=5005

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QUESTIONS?
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These slides will be posted on the vendor page of the CMS website. To view slides from previous workgroups, visit:

https://www.cms.gov/ehealth/vendors.Html