The year 2014 marked the fourth year of the Meaningful Use (MU) of certified electronic health record technology (CEHRT). Meaningful Use, designed to encourage providers to collect data in a structured format, has made great inroads in creating the infrastructure needed for health care data exchange, outcomes analysis and quality improvement. For providers who have successfully achieved MU, the opportunity to begin using the data residing in their CEHRT to engage in transformative initiatives and strategically improve practice revenue is only keystrokes away.

Many of Arkansas’ providers are either participating or considering participation in initiatives that align with the “triple aim”—improving the patient experience of care, improving the health of patient populations and reducing the per capita cost of health care. Among these initiatives are the Medicaid and Medicare electronic health record (EHR) incentive programs, the Arkansas Payment Improvement Initiative (APII), Million Hearts, Arkansas Patient-Centered Medical Home (PCMH), the Arkansas Clinical Transformation (ACT) collaborative, Physician’s Quality Reporting System (PQRS), the Comprehensive Primary Care Initiative (CPCI), and Accountable Care Organizations (ACOs), just to name a few. The progress and success of these programs in effecting transformation are heavily dependent on data. There is an intelligent trend towards aligning data requirements across these initiatives to reduce providers’ reporting burden.

Quality improvement efforts in health care settings often begin with a look at the practice’s clinical quality measures (CQM). Data are generally aggregated from the patients’ electronic medical record and billed claims. Providers who use certified EHR technology are experienced in reporting CQMs, which can identify a subset of patients by condition.

It is important for providers to understand the information that a clinical quality measure offers. For example, a CQM report for NQF #0059 — Diabetes: Hemoglobin A1C Poor Control would calculate a denominator comprised of “… patients 18-75 years of age who had a diagnosis of diabetes,” and a numerator indicating the number of patients in the denominator “… whose A1C was greater than 9.0.” The data presented will identify patients whose blood sugar is controlled and patients whose blood sugar is not controlled.

This presents an opportunity for a practice to bring back patients into the clinic for follow-up treatment, which can improve the patient’s health and increase practice revenue. By measuring this CQM, a decrease in the numerator over time would indicate an improvement in a health outcome for a defined set of patients: the number of patients whose blood sugar was poorly controlled.

The same process is applicable to other CQMs listed in the table: identifying populations of patients needing tobacco cessation intervention, and hypertensive patients whose blood pressure needs periodic monitoring. One can see from these examples alone that the data present powerful opportunities to effect interventions that can help improve the health of patient populations. The data contained in this manner in the patient’s record provides an opportunity to improve patient compliance, educate the patient and his or her family on self-management of chronic disease, and potentially reduce trips to the emergency room and hospitalizations.

Risk stratification of patients is one requirement of a number of transformative initiatives. This is done by analyzing patients who fall into high-risk categories. The data residing in EHRs—namely, patient diagnoses—can identify patients with multiple conditions...
A CLOSER LOOK AT QUALITY

Chronic diseases and assist the practice with developing care plans and reaching out to this patient population. Some EHRs offer a care management module or registry to facilitate data abstraction for these efforts.

Another use of data is the identification of patient populations needing preventive health. Arkansas Medicaid will pay primary care providers for early periodic screening, diagnosis and treatment for patients age 0 to 21. Medicare pays providers for “Welcome to Medicare” and health risk assessments, which “attribute” the Medicare patient to the provider who performs the service. Attribution is important when it comes to calculating shared savings in programs such as Arkansas PCMH and ACOs. To address the highly relevant public health priority regarding up-to-date immunizations and vaccinations, patients who have not received these services are identified, enabling the provider to engage patients to ensure that immunizations are current. Again, this data can be mined from most certified EHR technology.

Extracting data from certified EHR technology can range from the selection of a report or a combination of reports from an array of offerings provided by the EHR software developer, to using a more sophisticated add-on analytics or registry module to mine the data. Providers wishing to optimize the value of the certified EHR technology in which they have invested are wise to continue to train staff on how to put the technology to work for the practice. The extraction and strategic use of data are important parts of the return on investment.

As software developers continue to refine their EHR products, providers can look forward to more seamless interconnectivity with other EHRs, access to genomic patient profiles that will facilitate personalized care plans and more user-friendly functionality.

In 2015, the ability to extract data from CEHRT and report on clinical quality measures is vital to participation in the MU, PQRS, CPCi and PCMH initiatives, which pay incentives to providers. Additionally, Medicare providers will need to report data, including CQMs, in order to avoid the MU, PQRS and Value-Based Modifier payment reductions set for implementation in 2017.

Many Arkansas physicians, nurses and other healthcare professionals are working with the Arkansas Foundation for Medical Care (AFMC) to leverage MU to transform their practices and meet the requirements for new care delivery and payment reform programs. Small practices, federally qualified health centers (FQHCs) and critical access hospitals (CAHs) have achieved MU. They can now leverage health information technology (HIT) to deliver high-quality patient care and participate in new practice transformation programs that will ultimately help patients live healthier lives.

The strong foundation built through the MU of EHRs allows health care professionals to optimize more effectively their HIT investment to align with the triple aim of improving the patient experience of care, improving the health of patient populations and reducing the per capita cost of health care. ▲

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REFERENCES
2. CMS: Clinical Quality Measures for 2014 CMS EHR Incentive Programs for Eligible Professionals
3. www.ihi.org: The IHI Triple Aim

<p>| TABLE 1. Examples of highly relevant CQMs that align across specific reporting initiatives |
|-----------------------------------------------|----------|----------|----------|----------|</p>
<table>
<thead>
<tr>
<th>NQF #</th>
<th>CLINICAL QUALITY MEASURE DESCRIPTION</th>
<th>MU</th>
<th>PQRS</th>
<th>ACO</th>
<th>CPCi</th>
</tr>
</thead>
<tbody>
<tr>
<td>0018</td>
<td>Controlling High Blood Pressure: Percentage of patients 18-85 years of age who had a hypertension diagnosis and whose blood pressure was adequately controlled (&lt;140/90) during the measurement period</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>0028</td>
<td>Preventive Care and Screening — a) Tobacco Use Screening and b) Cessation Intervention: Percentage of patients ages 18 years and older who were screened for tobacco use one or more times within 24 months AND, if a tobacco user, received cessation counseling intervention</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>0059</td>
<td>Diabetes — Hemoglobin A1C Poor Control: Percentage of patients 18-75 years of age with diabetes who had hemoglobin A1C &gt; 9.0% during the measurement period</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>0064</td>
<td>Diabetes — Low Density Lipoprotein (LDL) Management: Percentage of patients 18-75 years of age with diabetes whose LDL-C was adequately controlled (&lt;100 mg/dL) during the measurement period</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
</tbody>
</table>