

Criteria that Could Be Advanced Further in Stage 2 with Additional Time

Improving Quality, Safety, Efficiency & Reducing Health Disparities

1. Recording of Demographics

Current state of criterion: 80% of patients have demographics recorded and can use them to produce stratified quality reports using more granular demographic categories per IOM report (add to existing fields in St. 2; add new fields in St. 3)

Proposed Increase in advancement: Require new fields in Stage 2

Why:

- Critical for addressing disparities, especially in areas with very diverse populations
- Additional time allows for additional coding, and will save re-work caused by 2-step process

2. Smoking status recorded

Current state of criterion: 80% of patients have smoking status recorded (add new field in certification for secondhand smoke)

Proposed Increase in advancement: Require new field for second hand smoke in Stage 2

Why:

- This should be considered a vital sign (as panelist at specialist hearing said)
- Second hand smoke is a critical factor for patients with pulmonary issues, and is a particular concern for children with asthma, one of the leading reasons for pediatric ED visits, making this information critical for home and self-management.
- Both vital signs and smoking status required in definitions of care summary documents
- Additional time allows for additional coding and could prevent rework, given existing need to code for vital signs and smoking status

3. Recording of Family health history

Current state of criterion: Consider for St. 3

Proposed Increase in advancement: Require use of structured family health history information in Stage 2

Why:

- Critical for prevention and early detection of disease
- Enables patient contributed data
- Offers means of using Health IT for consumer convenience (elimination of need to complete health history multiple times), which has been shown to be an effective way to engage patients in accessing provider portals
- Offers opportunity for more efficient information collection for providers, as well as increased accuracy of that information
- Important element of enabling risk assessment
- Can pave the way for eventual incorporation of genetic and genomic data into the electronic health environment
- Standards already exist and are in the process of being implemented by major vendors, such as Epic, Cerner, and others
- Open source, web-based tool developed by the Office of the Surgeon General updated in 2009 according to the standards completed in 2008.
- Has implications for cost reduction by enabling providers to use risk information to make clinical decisions about the necessity of genomic tests and other interventions.
- Supports 4 of the 5 policy priorities of MU
 - Standards accommodate patient contributed data (through web-based tool mentioned above)
 - Information is critical to clinical decision-making
 - Information could help in coordinating care by making risk assessment results available
 - Ultimately could be useful for public health purposes

Engaging Patients and Families

1. Electronic Copy of D/C Instructions

Current state of criterion: For Hospitals, ≥ 25 patients receive electronic discharge instructions at the time of discharge

Proposed Increase in advancement: Increase threshold to % OR increasing # by hospital size (25 for small, rural hospitals; 100 for mid-sized; 250 for large)

Why:

- Requirement of 25 patients – for larger hospitals – is easily accomplished in a day and would result in no change of the status quo.

2. Secure messaging

Current state of criterion: EPs: Patients are offered secure messaging online and ≥ 25 patients have sent secure messages online

Proposed Increase in advancement: At least 25% of all patients or 10% of a defined patient population have used patient messaging at least once

Why:

- Studies indicate that this is correlated with better outcomes on quality measures, enhanced efficiency of non-visit care, and improved provider productivity as measured by increased capacity for patient visits, and improved access to care for patients. (see recent CHCF report)
- Hard number is easy to meet without changing care delivery processes. This criterion has potential to have a significant impact on provider workflow in ways that enhance patient experience and ability to be engaged in their care
- This criterion builds a foundation for patient-contributed data, making a hard number less desirable than a percent

3. Patient-Contributed Data

Current state of criterion: Not a specific criterion; considered for Stage 3 in the form of “Information reconciliation” to correct errors in the medical record

Proposed Increase in advancement: Require capability for patient entered data in Stage 2 (via secure messaging, patient portal or other electronic means), and allow providers to select from a list of options that would meet the criteria:

- “Information reconciliation”
- Submission of family health history or HRA assessment results to physician
- Patient response to information prescription or other provider/patient “order” (Examples include: For pt ed resources: was information read, questions asked, what action was intended or completed, or submission of items for discussion at the next visit or encounter. In meds: confirmation that medication prescriptions have been filled or refilled. Reminders: appointment scheduled. Care plan: progress of care, referral appointments made, etc.)
- Submission of care team member list
- Online submission of experience of care information – either qualitative or quantitative – pending advice from ONC and Quality Measures work group.

Why:

- Building this capacity into systems is critical, both for advancement of patient and family engagement in health *and* health IT, and also for advancing our quality measurement capabilities
- Standards already exist for some of these uses (see family health history)
- This is an absolutely vital step to take for changing health care's culture from viewing patients as passive recipients of care to active members of the care team.

Improving Care Coordination

1. Provide summary of care record (and plan) for each transition and referral

Current state of Stage 2 draft criterion: EH: 10% of all discharges have summary of care record sent electronically to EP or other post-acute facility; EP: at least 25 transactions sent electronically (if exclusion for lack of electronic recipients, then must send on paper [need HIE preamble])

Proposed Increase in advancement:

- Both EP and EH: Use Direct or something comparable (could be HIE or other service like AAFP/SureScripts).
- For EP: make threshold 30%, not a hard number. Measure: denominator is # unique patients seen who also have a care team member(s) recorded. Numerator: # transmissions sent *and* received.
- Include in summary goals of treatment and patient instructions, which is shared with the patient.*

Why:

- Using above numerator and denominator, count can become automated
- Additional time will allow EPs and their vendors additional time for report creation
- A focus on counting absolute numbers, especially with such a small number, will severely undermine the ability of the objective and measure to incentivize HIE

2. List of care team members

Current state of criterion: List of care team members available for 10-20% of patients via electronic exchange; 10% of patients have a list of care team members (including PCP, if available) (unstructured data for stage 2; for stage 3, code by NPI)

Proposed Increase in advancement: 20% of patients have a list of care team members recorded, including PCP, when available. Names listed in individual fields for management purposes.

Why:

- Critical element of care plans.
- Additional time allows for vendors to create fields
- The great majority of care team members responsible for carrying out a care plan (nurses, care managers, social workers, etc) do not have NPIs, so need to accommodate entry of name/position/title.

3. Care plan

Current state of criterion: Merge with summary of care to create “summary and care plan”

Proposed Increase in advancement: 20% of patients have a care plan recorded that includes goals of treatment and patient instructions, and is shared with the patient.*

*Small subgroup of MU Workgroup is working on more detailed option for care plans.