

Health Information Technology: Tools for Community Quality Improvement

Wednesday, September 16, 2015

10:00 AM – 11:00 AM (PST)



Funding for this meeting was made possible by the Centers for Disease Control and Prevention. The views expressed in written conference materials or publications and by speakers and moderators do not necessarily reflect the official policies of the Department of Public Health, nor does the mention of trade names, commercial practices, or organizations imply endorsement by the U.S. Government.

California Department of Public Health



Mark Elson, PhD

Intrepid Ascent

Presentation for the *Lifetime of Wellness* / Prevention First Grantees

California Department of Public Health

Chronic Disease Control Branch

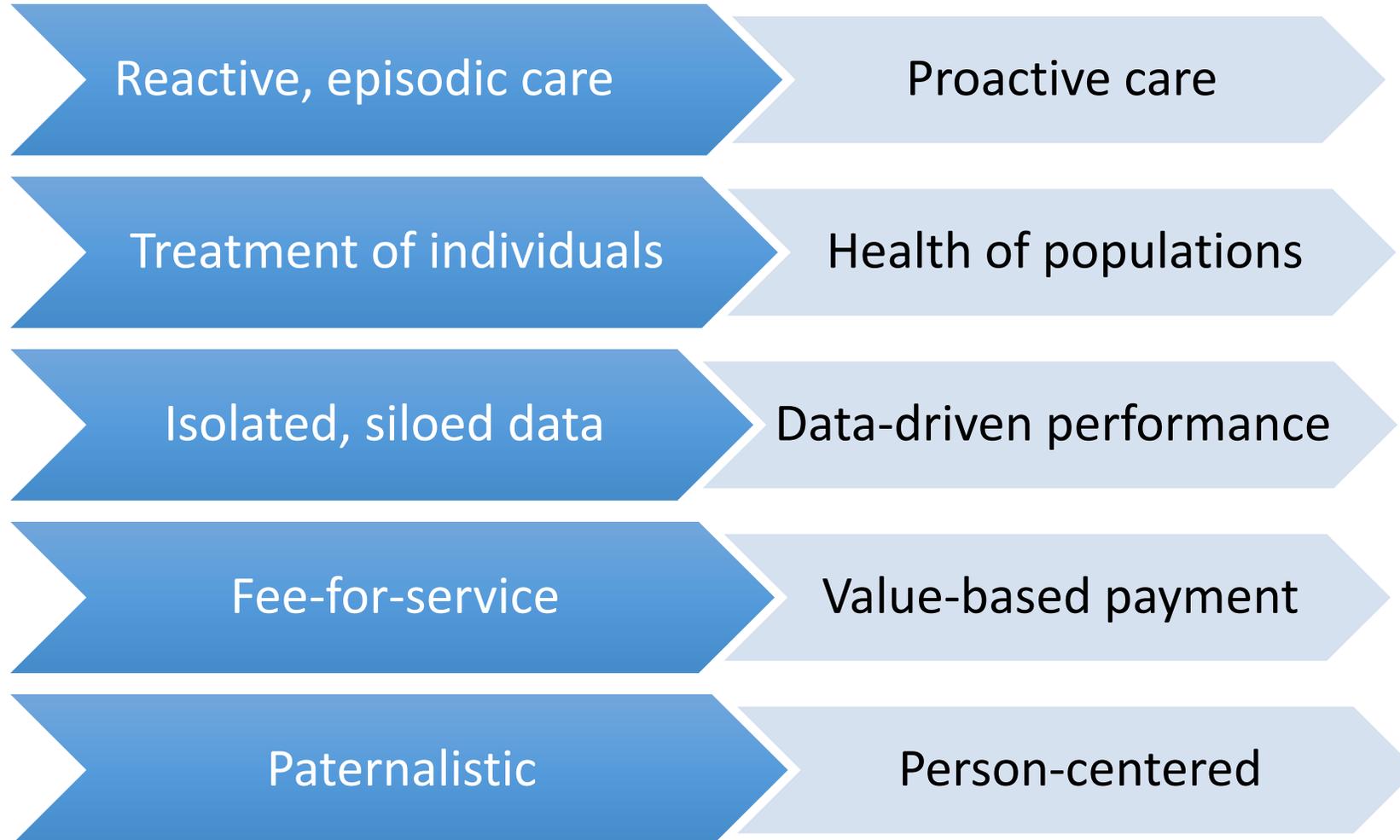




“You cannot step into the same river twice...”

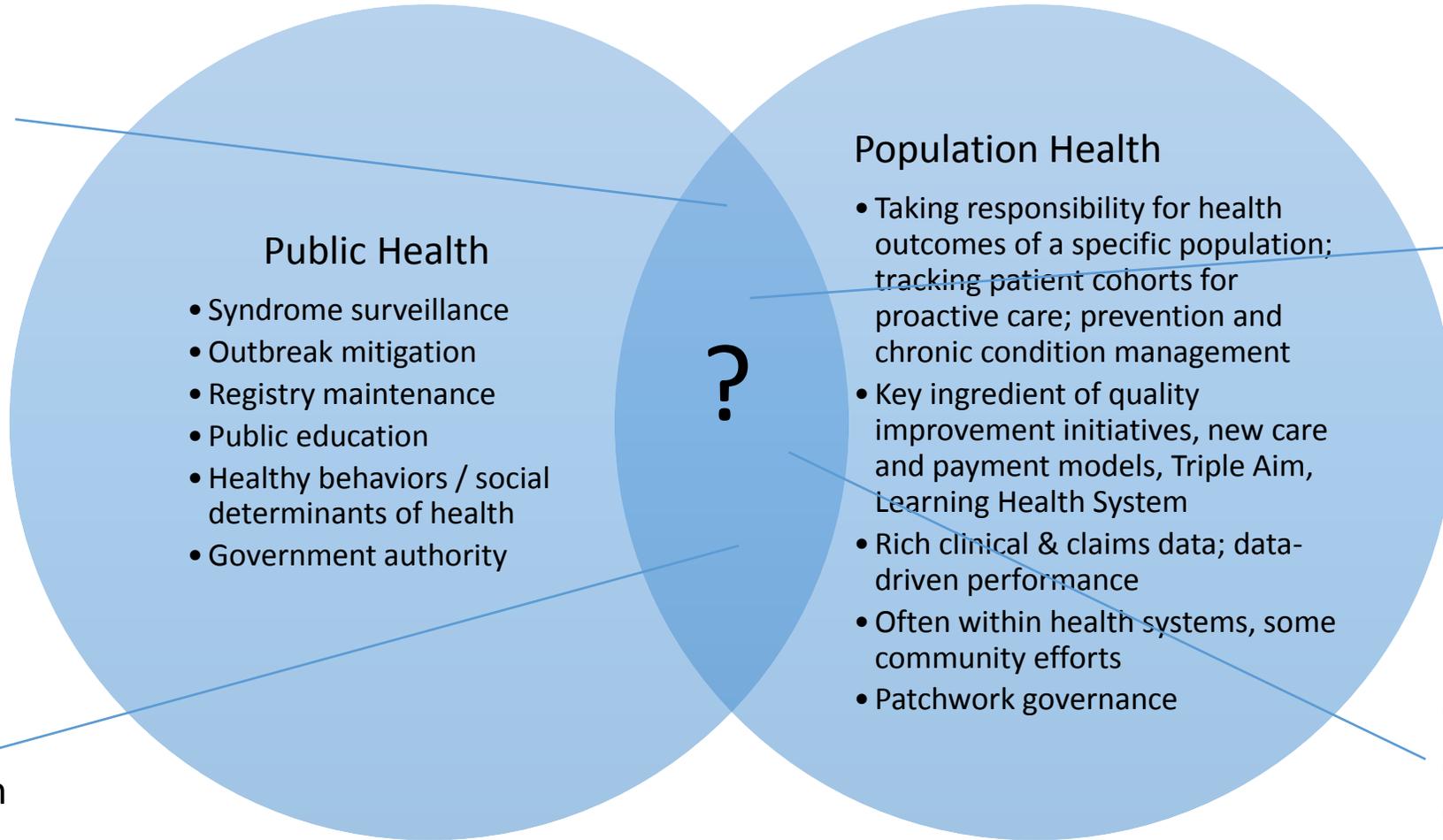
- Heraclitus

Healthcare Reform Currents





Prevention and wellness programs

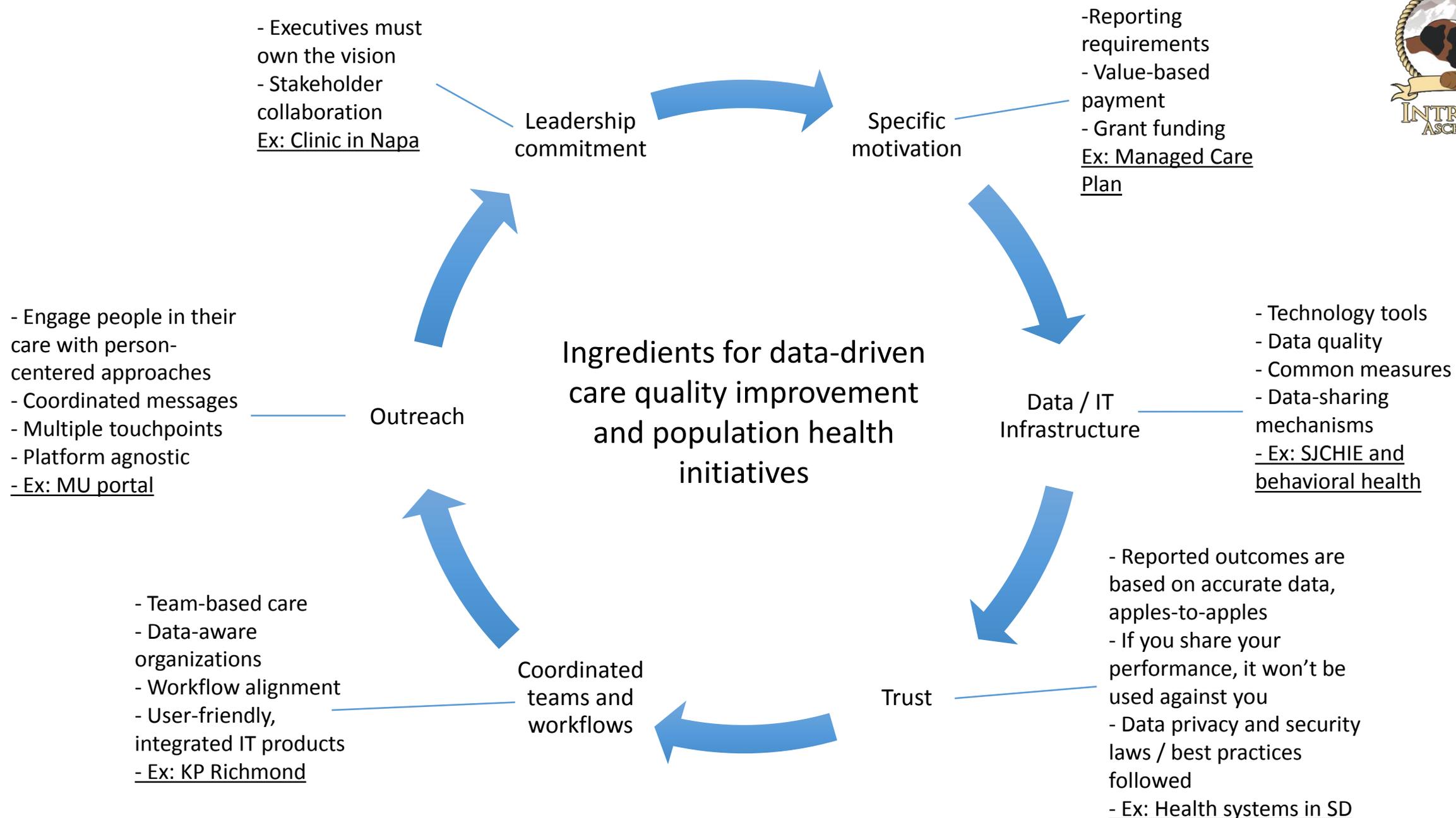


Epidemiology / data analytics

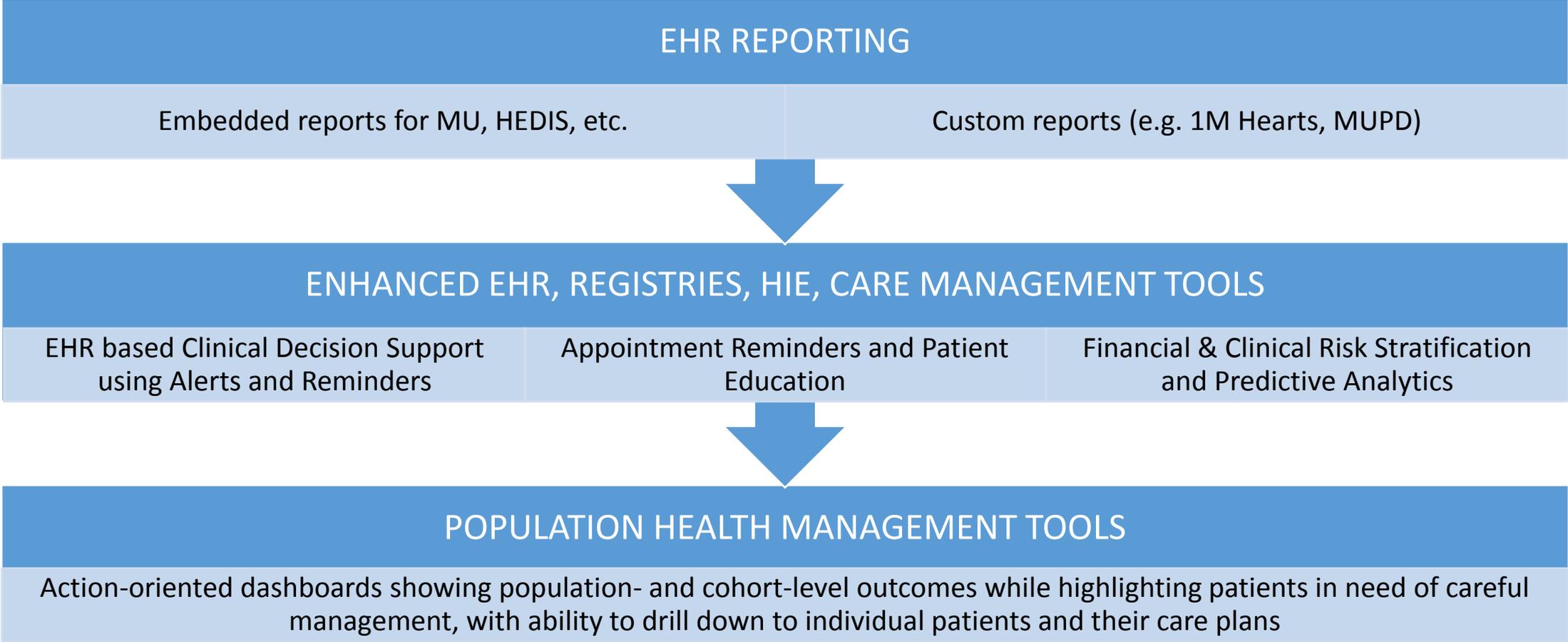
Outreach

Community data assets (HIE, bi-directional registries)

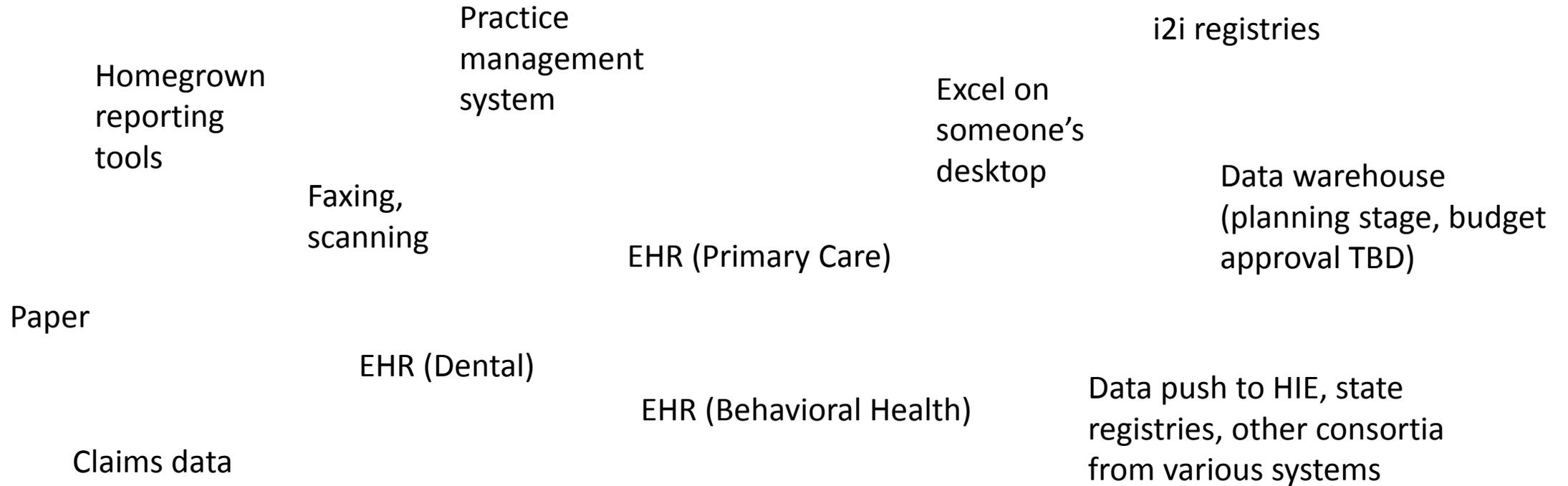
How can public health entities align with the momentum toward Population Health Management (PHM)?



Data Infrastructure Adoption Progression



Data Infrastructure Reality

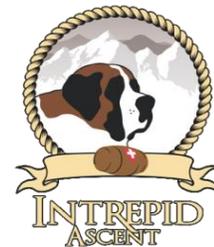


Silos, ad hoc integration, manual processes, poor data quality



EHRs and.... Everything Else

- EHR 2.0 Wave
 - EHR replacements quadrupled between 2013 and 2014
 - Many organizations consolidating to a single enterprise EHR
 - Cases of single EHR instances across multiple organizations for unified patient record (Ex. Southern California health systems – in planning; OCHIN model)
- Other Products
 - Health information exchange (HIE) has deep penetration in small number of communities, most not offering PHM yet but many plan to
 - Registries not a comprehensive solution
 - Homegrown solutions often not scalable
 - Population health management / care management platforms can be expensive
 - Overlapping product categories with innovation in market also creates confusion



Stage 2 Meaningful Use: PHM via EHRs

Stage 2 Meaningful Use: 17 Core Objectives

1. Use computerized provider order entry (CPOE) for medication, laboratory and radiology orders	10. Incorporate clinical lab-test results into Certified EHR Technology
2. Generate and transmit permissible prescriptions electronically (eRx)	11. Generate lists of patients by specific conditions to use for quality improvement, reduction of disparities, research, or outreach
3. Record demographic information	12. Use clinically relevant information to identify patients who should receive reminders for preventive/follow-up care
4. Record and chart changes in vital signs	13. Use certified EHR technology to identify patient-specific education resources
5. Record smoking status for patients 13 years old or older	14. Perform medication reconciliation
6. Use clinical decision support to improve performance on high-priority health conditions	15. Provide summary of care record for each transition of care or referral
7. Provide patients the ability to view online, download and transmit their health information	16. Submit electronic data to immunization registries
8. Provide clinical summaries for patients for each office visit	17. Use secure electronic messaging to communicate with patients on relevant health information
9. Protect electronic health information created or maintained by Certified EHR Technology	



Meaningful Use eCQM Requirements

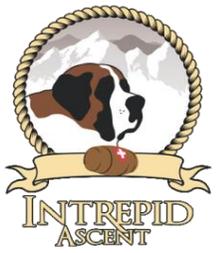
- Report on 9 eCQMs across 3 National Quality Strategy Domains
 - Patient and Family Engagement
 - Patient Safety
 - Care Coordination
 - Population / Public Health
 - Efficient Use of Healthcare Resources
 - Clinical Process/Effectiveness
- Recommended Core Sets for adults and children



NQF Measures 18 and 59 – MU eCQMs

NQF Measure # / CMS eCQM	Description	National Quality Strategy Domain	In recommended set for Eps?
NQF 18 CMS 165v1	Controlling high blood pressure	Clinical process / effectiveness	Yes – for adults
NQF 59	HbA1c Poor Control	Clinical process / effectiveness	No

- Prevention First / Lifetime of Wellness environmental scans will identify provider organizations tracking these measures
- Pair this knowledge of data infrastructure with an understanding of existing quality improvement / pop health initiatives on hypertension and diabetes in your community



Lifetime of Wellness / Prevention First

- Modest initial scope, potential to expand
- Community focus with technical assistance role for LHDs
- Environmental scan great place to start
 - Questions about EHRs, Meaningful Use, quality reporting, HIE
 - Consider including health plans in program
- Hypertension and diabetes
 - Ideal chronic conditions for public health / population health convergence
 - Prevention, patient self-management, team-based care
 - Leverage existing quality improvement / pop health initiatives in your community focused on these conditions

Million Hearts Initiative Measures



Domain	Measure	National Quality Forum (NQF)	CMS Physician Quality Reporting System (PQRS)	CMS Medicare EHR Incentive Program
Aspirin When Appropriate	Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antithrombotic Percentage of patients aged 18 years and older with IVD with documented use of aspirin or other antithrombotic	#0068	#204	CMS164v2
Blood Pressure Screening	Preventive Care and Screening: High Blood Pressure Percentage of patients aged 18 years and older who are screened for high blood pressure AND a recommended follow-up plan is documented based on the current blood pressure readings as indicated	n/a	#317	CMS22v2
Blood Pressure Control	Hypertension (HTN): Controlling High Blood Pressure Percentage of patients aged 18 through 85 years who had a diagnosis of HTN and whose blood pressure was adequately controlled (<140/90) during the measurement year	#0018	#236	CMS165v2
Cholesterol Management	Preventive Care and Screening: Cholesterol—Fasting Low Density Lipoprotein (LDL) Test Performed AND Risk-Stratified Fasting LDL Percentage of patients aged 20 through 79 years who had a fasting LDL test performed and whose risk-stratified fasting LDL is at or below the recommended LDL goal.	n/a	#316	CMS61v3 CMS64v3
Cholesterol Management – Diabetes	Diabetes Mellitus: Low Density Lipoprotein (LDL-C) Control in Diabetes Mellitus Percentage of patients aged 18 through 75 years with diabetes mellitus who had most recent LDL-C level in control (less than 100 mg/dL)	#64	#2	CMS163v2
Cholesterol Management – Ischemic Vascular Disease	Ischemic Vascular Disease (IVD): Complete Lipid Panel and Low Density Lipoprotein (LDL-C) Control Percentage of patients aged 18 years and older with Ischemic Vascular Disease (IVD) who received at least one lipid profile within 12 months and who had most recent LDL-C level in control (less than 100 mg/dL)	#0075	#241	CMS182v3
Smoking Cessation	Preventive Care and Screening: Tobacco Use Percentage of patients aged 18 years and older who were screened about tobacco use one or more times within 24 months and who received cessation counseling intervention if identified as a tobacco user	#0028	#226	CMS138v2



Solano County Health Hub

- Population and Public Health Hub (PPHealthHub)
- Portal simplifies MU and public health reporting
- Harvests data for community-level analysis to inform collaborations to improve community health
- Embedded in vision for “Healthy People – Healthy Community”

<http://solanohealthhub.org/>

Solano County addressing
all elements of this cycle





Follow the Data

- Data is like water flowing through the Learning Health System, enabling growth and improvement
- Many dams and isolated watersheds, but change is underway
- Identify the data that will sustain your quality interventions
- Understand where it comes from, who's using it and why, how it's structured, and map its flow

Then boldly step into the river!

Contact Information

Mark Elson, PhD

Principal

Intrepid Ascent

mark@intrepidascend.com



Funding for this presentation was made possible by the Centers for Disease Control and Prevention and the California Department of Public Health. The views expressed in written presentation materials and by the speaker do not necessarily reflect the official policies of the Department of Health and Human Services, nor does the mention of trade names, commercial practices, or organizations imply endorsement by the U.S. Government.

Questions?

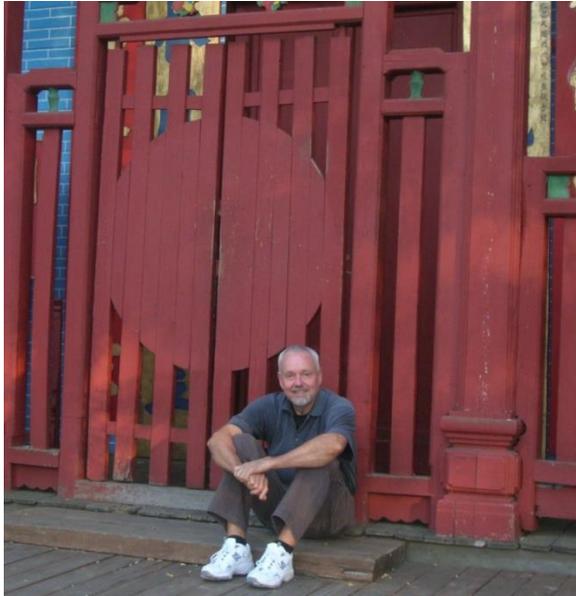


Mark Elson, PhD



mark@intrepidascend.com

CDPH Staff – Thank you!



Bob Thurman
Program Manager
Prevention First
Robert.Thurman@cdph.ca.gov
Phone 916-650-0228



Lisa E. Rawson
Program Manager
Lifetime of Wellness
Lisa.Rawson@cdph.ca.gov
(916) 552-9916



Alexandria Simpson
CVD Health Systems Interventions Lead
Lifetime of Wellness & Prevention First
Alexandria.Simpson@cdph.ca.gov
(916) 552-9950