Leveraging Meaningful Use to Assist in Reducing Hospital Readmissions

Key Health Alliance

Regional Extension Assistance Center for HIT

Paul Kleeberg, MD, FAAFP, FHIMSS
CMIO, Stratis Health

RARE Campaign Webinar

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Objectives

- Identify the link between quality and patient safety efforts to meaningful use requirements
- Understand how Shared Decision-Making, informed consent, care coordination, sharing of information is supported by the meaningful use criteria
- Describe the role the progressive certification criteria for EHRs will play in opening up EHRs to other settings/users through the facilitation of standards for exchange
- Identify the meaningful use criteria and quality measures that can help reduce hospital readmissions

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Patients who are readmitted*

- The result of the fragmentation of care:
  - Inadequate preparation for post-discharge care.
  - Poor transmission of records and discharge instructions.
  - Uncoordinated post-hospital care.
  - Preventable medical errors/complications during the first hospital stay.
- The highest rates of readmitted patients:
  - Have heart failure, chronic obstructive pulmonary disease (COPD), psychoses, intestinal problems, and/or have had various types of surgery (cardiac, joint replacement, or bariatric procedures).
  - Take six or more medications, have depression and/or poor cognitive function, and/or have been hospitalized in the previous six months.
  - Are discharged on weekends and holidays

* Source: National Priorities Partnership Compact Action Brief, "Preventing Hospital Readmissions: A $25 Billion Opportunity"

What is Meaningful Use?

- The requirement to have certified software
  - Standards to capture data and store it in a format that can be exchanged
    - LOINC for labs
    - ICD for diagnoses
- The requirement to have certain basic elements recorded in a patient's chart
  - Problems, medications, allergies
- The requirement to share this information
  - Referral summaries, electronic exchange, registries

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What is in the Stage 2 Final Rule?

- In general:
  - Most stage 1 menu criteria will become core
  - Required percentages increase
  - Turnaround time shorter
  - More exchange and patient involvement
  - Some core functional measures incorporated into other activities
  - More data elements defined and required

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5 Key Areas Known to Reduce Avoidable Readmissions

1. Comprehensive discharge planning.
2. Medication management
3. Patient and family engagement
4. Transition care support
5. Transition communications

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1st Key Area: Comprehensive discharge planning

- Focus on ensuring that all of a patient's needs are considered and included in a comprehensive discharge plan with input from the patient and family that include:
  - Follow-up appointments
  - Medications
  - Nutritional needs
  - Family support
  - Transportation
  - Health literacy
  - Knowing whom to call
  - Social problems
  - Red flags.

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Foundation of Discharge Planning

- Starts at time of admission
- A comprehensive picture of the patient and his/her needs
- Supported by several stage 1 MU Criteria
  - Demographics, problem list, medications, allergies, vital signs, advanced directives, electronic copies of health information and discharge instructions, summary of care record and exchange
- Enhanced by Stage 2 MU Criteria
  - Standards for electronic notes, listing of the care team and other clinical elements can be captured in discrete form

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2nd Key Area: Medication management

- Focus on improving the use of medications for the patient's condition and ensuring that the patient understands the purpose of the medications and is taking them in the correct manner at the correct time. Interventions may include:
  - medication reconciliation
  - patient/family education on medications
  - medication therapy management
  - medication set-up simulations for the patient/ family.

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Meaningful Use Criteria Supporting Medication Management

- Stage 1:
  - Problem lists / diagnoses
  - Drug-drug and drug-allergy interactions
  - Medication formularies
  - Medication reconciliation
  - Patient education resources
  - Electronic discharge summaries
- Stage 2:
  - eMAR with med tracking from order to administration
  - E-Rx for discharge prescriptions
  - Electronic progress notes

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3rd Key Area: Patient and Family Engagement

- Focus on ensuring that processes are in place to engage patients/family, elevate the status of family caregivers as essential members of the team, and prepare the patient and family to manage care at home. Methodologies include:
  - teach back
  - collaborative conversations and communication
  - simulations with the patient and family member.

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Meaningful Use Criteria Supporting Patient and Family Engagement

- Stage 1:
  - Electronic copy of a patient's health summary
  - Electronic copy of a patient's discharge instructions
  - Patient education resources
- Stage 2:
  - Provide online access to health information and measure patients / care providers accessing it
- 2014 Certification Criteria:
  - Provide patients the ability to view online, download, and transmit information about a hospital admission

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4th Key Area: Transition care support

- Focus on ensuring that transition plans are in place and followed so that the patient's care is coordinated among caregivers. Interventions may include:
  - Next clinic appointment is made and documented
  - Discharge instructions include warning signs and symptoms, whom to call if experiencing warning signs and symptoms
  - Teach back for patient education is documented
  - Primary clinician and primary clinician's clinic is documented
  - Problem list is up-to-date with current and active diagnoses
  - Medication list is up-to-date, active
  - Electronic copy of health information is provided to patients; discharge summary and procedures for hospitals
  - Post discharge follow-up call is made within 24 hours of discharge
  - Percent reached by follow-up phone call within 24 hours of discharge
  - Follow-up appointment with medication reconciliation occurs within a specified number of days of discharge

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MU Criteria Supporting Transitions of Care

- Making sure the right people have the right information to meet a patient's needs
- Stage 1 Criteria
  - Problems, meds, allergies, lab results
  - Summary of care record
  - Medication reconciliation at each transition of care
  - Electronic copy of key information is provided when requested
- Stage 2 Criteria
  - Provide patients the ability to view online, download, and transmit information about a hospital admission

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5th Key Area: Transition Communications

- Focus on ensuring that effective communication occurs between sending and receiving care givers working with the hospital, e.g., home care, home, primary/specialty care, skilled nursing facility or rehab. Interventions may include:
  - processes for transferring information
  - providing discharge summaries in a timely manner
  - defining accountability for care
  - communication of the plan of care
  - methods for talking directly with sending or receiving caregivers
  - definition of key information which may include:
    - current health status
    - follow-up needs
    - pending test results
    - red flags
    - Medications
    - special patient needs.

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MU Criteria Supporting Transition Communications

- Facilitating the exchange of information among providers of a patient's care
- Stage 1 Criteria
  - Summary of care record
  - Electronic exchange of key information
- Stage 2 Criteria
  - Provide online access to health information and measure patients / care providers accessing it
  - Provide summary of care document for transitions and referrals with a certain number sent electronically and across EHR vendors

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2014 Cert Reqs for Online Health Info and eTransmittal of Summary of Care

- All Providers:
  - The stage 1 criteria Plus:
    - Provider's name and contact information; names and contact information of any additional care team members; and care plan, including goals and instructions.
- Hospital Setting:
  - The stage 1 criteria plus:
    - Admission and discharge dates and locations; reason(s) for hospitalization; names of providers of care during hospitalization; functional status; laboratory tests and values/results (available at time of discharge); and discharge instructions for patient.

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Quality And Patient Safety Efforts Link to Meaningful Use Requirements

- Computerized provider order management (entry) and ePrescribing
- Drug interactions and Clinical Decision Support
- eMAR with bar code med admin (stage 2)
- Quality measures with reporting

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Shared Decision Making and Coordination Link to Meaningful Use

- Shared decision-making, informed consent, care coordination, sharing of information are supported by the meaningful use criteria
  - Meaningful criteria define a medium in which information about a patient can be collected and documented in such a way that it can be followed longitudinally and shared with others
  - Tools:
    - Vocabularies (Examples: ICD, SNOMED, LOINC, RxNorm)
    - Structure (Consolidated CDA, DICOM)
    - Transport: (SOAP Secure transport, XDR and XDM for direct messaging)

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The Role of the Progressive Certification Criteria

- The role the progressive certification criteria for EHRs will play in opening up EHRs to other settings/ users through the facilitation of standards for exchange
  - 2011 Standards focus on data collection
    - Problems, meds, allergies, advanced directive...
  - 2014 standards
    - Base EHR:
      - Sets the standards that can be used by all providers of care
    - More data collection standards defined
      - Care team
      - Care plan
    - Enhanced standards and requirements for data exchange

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Base EHR

Certification Criteria Required to Satisfy the Definition of a Base EHR	
Base EHR Capabilities	**Certification Criteria**
Includes patient demographic and clinical health information, such as medical history and problem lists	Demographics § 170.314(a)(3) Problem List § 170.314(a)(5) Medication List § 170.314(a)(6) Medication Allergy List § 170.314(a)(7)
Capacity to provide clinical decision support	Clinical Decision Support § 170.314(a)(8)
Capacity to support physician order entry	Computerized Provider Order Entry § 170.314(a)(1)
Capacity to capture and query information relevant to health care quality	Clinical Quality Measures § 170.314(c)(1) and (2)
Capacity to exchange electronic health information with, and integrate such information from other sources	Transitions of Care § 170.314(b)(1) and (2)
	Data Portability § 170.314(b)(7)
Capacity to protect the confidentiality, integrity, and availability of health information stored and exchanged	Privacy and Security § 170.314(d)(1) through (8)

The meaningful use quality measures that can help reduce readmissions (1)

- The highest rates of readmitted patients:
  - Have heart failure
    - Beta-blocker therapy for left ventricular systolic dysfunction (EP)
    - ACE inhibitor or ARB therapy for left ventricular systolic dysfunction (EP)
    - Warfarin therapy patients with atrial fibrillation (EP Revised in 2014)
  - Have had various types of surgery (cardiac, joint replacement, or bariatric procedures).
    - Prophylactic Abx selection, administration (SCIP) (EH 2014)
    - Urinary catheter removal POD1 (SCIP) (EH 2014)
    - VTE prophylaxis, overlap therapy and discharge Instructions (EH)
    - Chronic wound care (2014)
  - No EH or PEP measures directly address these patients:
    - Chronic obstructive pulmonary disease (COPD)
    - Psychoses
    - Intestinal problems

The meaningful use quality measures that can help reduce readmissions (2)

- The highest rates of readmitted patients (cont.):
  - Take six or more medications
    - Use of high risk medications in elderly (EP 2014)
    - Documentation of medication list including OTCs and herbals (EP 2014)
  - Have depression and/or poor cognitive function
    - Depression screening (EP 2014)
    - Dx and Rx of depression (EP 2014)
    - Cognitive assessment (EP 2014)
    - Screening for fall risk (EP 2014)
  - Have been hospitalized in the previous six months
- Caregiver
  - Caregiver education and support (EH 2014)
  - Home Management Plan of Care Document Given to Patient/ Caregiver for pediatric asthma (EH 2014)
- Care team
  - Receipt of referral report from specialist (EP 2014)

Stage 1 Criteria:

Including changes from Stage 2 rule

Core:

- Demographics
- Problem list
- Medication list
- Medication allergy list
- Provider order entry
- E-Prescribing (EP only)
- Vital signs
- Smoking status
- E-copy of their health information
  - Removed after 2013
- Electronic discharge instructions (EH) or clinical summaries (EP)
  - Removed after 2013
- Report Clinical Quality Measures
  - redundant, eliminated after 2012
- Drug (D-A, D-D) Interactions
- Clinical decision support
- Electronic exchange
  - Not required after 2012
- Protect electronic health information
- New for 2014:
  - E-access to hospital / health info

Menu:

- Provide education resources
- Advanced directives (EH)
- Patient reminders (EP)
- Labs as structured data
- Medication reconciliation
- Summary of care record
- Drug - formulary checks
- Patient list by specific condition
- Test of submission of electronic data to immunization registries.
- Test of submission of reportable labs to public health. (EH)
- Test of providing electronic syndromic surveillance data to public health agencies.

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In Summary

- Meaningful use provides:
  - The platform for preparing a patient for discharge
  - A medium that the team can use to share information among themselves (without having to search for the chart)
  - A way to share this information with others in such a way that it is useful
  - Will progress to allow for greater portability of a person's record and enable
    - Comprehensive discharge planning
    - Medication management
    - Patient and family engagement
    - Transition care support
    - Transition communication

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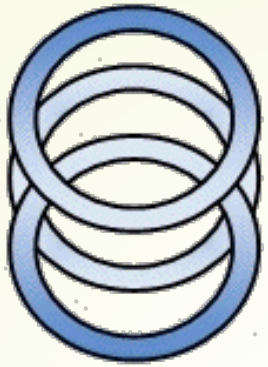

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Paul Kleeberg, MD, FAAFP, FHIMSS

pkleeberg@stratishealth.org

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