Epic EHR workflows for CPC+

Wednesday 6/13/2018
12:30 to 1:30 - Presentation & EHR workflows
1:30 to 2:00 – Review of Resources and Q & A

Carl Barton & Anna Smolentzov
Agenda

• Introductions
• Key learning objectives
• Examples of Comprehensive Primary Care Plus (CPC+) Quality Improvement (QI) projects with demonstrated Epic EHR workflows
• Review of Resources
Introductions

• Mountain-Pacific Quality Health
  – Carl Barton – Healthcare Transformation Consultant
  – Barry Major – Practice Facilitator – CPC+ Hawaii Region

• Hawaii Pacific Health
  – Anna Smolentzov - Business Systems Analyst

• Hawaii Department of Health (DOH) – Centers for Disease Control and Prevention (CDC) 1305 funding focus
  – Improve control of diabetes and high blood pressure through support for QI, CQM reporting, use of HIT, team-based care and referral to community resources
  – Improve identification of potential hypertension, pre-diabetes and diabetes which is not coded
Key Learning Objectives

- Navigate the Epic EHR workflows that directly align with CPC+ Care Delivery Requirements, eCQMs and Quality Improvement
- Be able to navigate resources available to assist your practice
Polling Question 1

I am planning on reporting...

- All quality measures
- Only the required number of quality measures
Important Note!

Utilizing the correct workflows of your EHR can ensure you get paid based on the actual quality of the care you are delivering.
Technical Assistance

• Review of resources for Hypertension, Tobacco Use Screening/Cessation and Diabetes
  – Million Hearts resources
  – Mountain-Pacific resources
  – Review and support with community resources
    ▪ Diabetes Education and Prevention programs (DPP & DSME)
    ▪ Lifestyle programs
    ▪ Smoke Cessation programs

• Program Guidance for CPC+
• Assessment of your practice’s approach to team based care and self-management support
• Review methodologies like PDSA and eCQI

Contact Carl Barton at cbarton@mpqhf.org or (808) 440-6015 if you can use additional technical assistance in the next two weeks
## Clinical Quality Measures (CQMs)

<table>
<thead>
<tr>
<th>Measure</th>
<th>CMS / MIPS ID</th>
<th>Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>BP Control</td>
<td>165/236</td>
<td>Outcome</td>
</tr>
<tr>
<td>A1c Control</td>
<td>122/001</td>
<td>Outcome</td>
</tr>
<tr>
<td>Nephropathy Screening</td>
<td>134/119</td>
<td>Process</td>
</tr>
<tr>
<td>DM Eye Exam</td>
<td>131/117</td>
<td>Process</td>
</tr>
<tr>
<td>Depression Screening</td>
<td>2/418</td>
<td>Process</td>
</tr>
<tr>
<td>Utilization of PHQ-9</td>
<td>160/712</td>
<td>Process</td>
</tr>
<tr>
<td>Dementia: Cognitive Assessment</td>
<td>149/2872</td>
<td>Process</td>
</tr>
<tr>
<td>Screening for Falls</td>
<td>139/101</td>
<td>Process</td>
</tr>
<tr>
<td>High Risk Rx in the Elderly</td>
<td>156/22</td>
<td>Process</td>
</tr>
</tbody>
</table>
Polling Question 2

I check my CPC+ Dashboard in Epic

- On a regular basis, at least monthly
- Approximately quarterly
- Infrequently
- I have a dashboard?
CPC+ Example # 1

- Project:
  - Establish care plans for high risk DM patients OR uncontrolled HTN

- Project Changes/Improvements
  - Identify population with EHR
  - Implement a care management workflow for empaneled patients to include pre-visit planning, establishing care plans/goals (in EHR), care coordination/follow up, self management support and enhanced patient engagement and patient education
  - Train staff on accurate BP measurements → MH - BP protocol
  - Enhanced communication (secure messaging, phone, etc.)
  - Implement CDS rules to support changes
  - Group visits or another alternative visit type
  - Increase referrals to lifestyle/self management programs
CPC+ Example # 1 Scoring

• eCQMs
  – 134 (DM nephropathy), 122 (DM A1c Poor Control), and 131 (DM eye Exam) OR 165 (controlling hypertension)

• Care Delivery Requirements
  – Define at least one sub population with complex needs and provide additional support
  – Use of care plans to establish and track goals
  – Alternative visit types (telephone, group visits, assisted living, etc.)
  – Utilize community resources
  – Implement self-management support
EPIC EHR WORKFLOWS FOR CPC+
eCQMs in Epic

• How to enter reportable data in Epic
• New tool to enter data: Results Console
• How to see if a patient is meeting a measure or not
CMS-134: Diabetes: Medical Attention for Nephropathy

• What does the measure say?
  – Bulletins on AskIT
CMS-134: Diabetes: Medical Attention for Nephropathy

• “The percentage of patients 18-75 with diabetes who had a nephropathy screening test or evidence of nephropathy during the measurement period.”

• How to document:
  – Patients with diabetes
  – Patients with evidence of nephropathy
  – Taking an ACE inhibitor or ARB
  – A nephropathy screening test performed
CMS-134: Diabetes: Medical Attention for Nephropathy

- Patients with diabetes
  - Problem List & Visit Diagnoses

- Patients with evidence of nephropathy
  - Problem List & Visit Diagnoses

- Taking an ACE inhibitor or ARB
  - Medication List

- A nephropathy screening test performed
  - Lab orders
  - Results Console – for external lab results
CMS-122: Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%)

- What does the measure say?
  - Bulletins on AskIT
CMS-122: Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%)

• “Percentage of patients 18-75 years of age with diabetes who had hemoglobin A1c > 9.0% during the measurement period.”

• Inverse measure: lower score is better!

• How to document:
  – Patients with diabetes
  – Lab result
CMS-122: Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%)

- Patients with diabetes
  - Problem List & Visit Diagnoses
- Hemoglobin A1c result
  - Lab orders
  - Results console – for external results
eCQMs Per Patient

• How do you see how a patient is doing?
• Quality Navigator
  – Shows measures that a patient meets and does not meet
CMS-131: Diabetic Eye Exam

“Percentage of patients 18-75 years of age with diabetes who had a retinal or dilated eye exam by an eye care professional during the measurement period or a negative retinal exam (no evidence of retinopathy) in the 12 months prior to the measurement period.”

How to document:

– Patients with diabetes: Problem List and Visit Diagnoses
– Eye exam performed: Results Console
– Eye exam result (negative): Results Console
CMS-165: Controlling High Blood Pressure

• “Percentage of patients 18-85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90mmHg) during the measurement period.”

• How to document:
  – Patients with hypertension: Problem List
  – Blood pressure: Vitals
  – Results console necessary?: No!
eCQMs Recap

- CMS-134: Diabetes: Medical Attention for Nephropathy
- CMS-122: Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%)
- CMS-131: Diabetic Eye Exam
- CMS-165: Controlling High Blood Pressure
CPC+ Dashboard

• How do you see your eCQM scores in Epic?
CPC+ Dashboard

**CPC+ Group 1 Outcome Measures**
- CMS 122: Diabetes Hemoglobin A1c Poor Control
  - Q2 '17: 8%
  - Q3 '17: 8%
  - Q4 '17: 9%
  - YTD: 11%
- CMS 165: Controlling High Blood Pressure
  - Q2 '17: 74%
  - Q3 '17: 75%
  - Q4 '17: 72%
  - YTD: 72%

**CPC+ Group 2 Other Measures**
- CMS 2: Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan
- CMS 50: Closing the Referral Loop: Receipt of Specialist Report
- CMS 126: Cervical Cancer Screening
- CMS 125: Breast Cancer Screening
- CMS 127: Pneumococcal Vaccination Status for Older Adults
- CMS 130: Colorectal Cancer Screening

**Dashboard Features**
- View Quarter
- See Providers (This Measure)
- See Providers (All Measures)
- View Graph
### Quality Measures Summary

#### Group 1 Outcome Measures

<table>
<thead>
<tr>
<th>Measure Name</th>
<th>Initial Population</th>
<th>Denominator</th>
<th>Numerator</th>
<th>Performance Rate</th>
<th>Exclusion</th>
<th>Exception</th>
</tr>
</thead>
<tbody>
<tr>
<td>CMS 122 Diabetes: Hemoglobin A1c (HbA1c) Poor Control (&gt; 9%) (Lower Score is Better)</td>
<td>158</td>
<td>157</td>
<td>21</td>
<td>13.4%</td>
<td>1</td>
<td>N/A</td>
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<tr>
<td>CMS 165 Controlling High Blood Pressure</td>
<td>544</td>
<td>532</td>
<td>333</td>
<td>62.6%</td>
<td>12</td>
<td>N/A</td>
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#### Group 2 Other Measures

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<tr>
<th>Measure Name</th>
<th>Initial Population</th>
<th>Denominator</th>
<th>Numerator</th>
<th>Performance Rate</th>
<th>Exclusion</th>
<th>Exception</th>
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<tbody>
<tr>
<td>CMS 2 Preventive Care and Screening: Screening for Depression and Follow-Up Plan</td>
<td>1107</td>
<td>1034</td>
<td>852</td>
<td>82.2%</td>
<td>73</td>
<td>0</td>
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<tr>
<td>CMS 50 Closing the Referral Loop: Receipt of Specialist Report</td>
<td>285</td>
<td>285</td>
<td>21</td>
<td>74.4%</td>
<td>N/A</td>
<td>N/A</td>
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<tr>
<td>CMS 124 Cervical Cancer Screening</td>
<td>430</td>
<td>408</td>
<td>267</td>
<td>65.5%</td>
<td>22</td>
<td>N/A</td>
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<tr>
<td>CMS 125 Breast Cancer Screening</td>
<td>271</td>
<td>222</td>
<td>211</td>
<td>96.0%</td>
<td>2</td>
<td>N/A</td>
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## CPC+ Dashboard: Drilldown Report

<table>
<thead>
<tr>
<th>Patient Name</th>
<th>Outcome</th>
<th>MRN</th>
<th>Birth Date</th>
<th>QRDA Patient Ethnicity</th>
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### Controlling High Blood Pressure

**Measure Description**

**Outcomes**

- Outcome from the last run (6/11/2018): Met
- Expected outcome for the next run: Met

**Population Criteria**

Outcome: Met

Patients whose blood pressure at the most recent visit is adequately controlled (systolic blood pressure less than 140 mmHg and diastolic blood pressure less than 90 mmHg) during the measurement period.
CPC+ Dashboard: Drilldown Report Logic

Outcomes

Outcome from the last run (6/11/2018):
Not Met

Expected outcome for the next run:
Not Met

Population Criteria

Outcome: Not Met
Patients 18-85 years of age who had a diagnosis of essential hypertension within the first six months of the measurement period or any time prior to the measurement period whose blood pressure at the most recent visit is not adequately controlled (systolic blood pressure greater than or equal to 140 mmHg and diastolic blood pressure greater than or equal to 90 mmHg).

Initial Population / Denominator
Patients 18-85 years of age who had a diagnosis of essential hypertension within the first six months of the measurement period or any time prior to the measurement period.

Denominator Exclusions
Patients with evidence of end stage renal disease (ESRD), dialysis or renal transplant before or during the measurement period. Also, exclude patients with a diagnosis of pregnancy during the measurement period.
Exclude patients who were in hospice care during the measurement year.

Numerator
Patients whose blood pressure at the most recent visit is adequately controlled (systolic blood pressure < 140 mmHg and diastolic blood pressure < 90 mmHg) during the measurement period.

Most recent: Occurrence A of Encounter, Performed: Adult Outpatient Visit satisfies all Offic/Outpt E&M Estab Low-Mod
during Measurement Period
overlaps Physical Exam, Performed: Diastolic Blood Pressure (result)
overlaps Physical Exam, Performed: Systolic Blood Pressure (result)
overlaps Occurrence A of Diagnosis: Essential Hypertension

View 1 More Evaluated Result

AND Occurrence A of Diagnosis: Essential Hypertension satisfies all
Essential hypertension, benign
starts before start of Occurrence A of Encounter, Performed: Adult Outpatient Visit
overlaps Occurrence A of Encounter, Performed: Adult Outpatient Visit
AND Physical Exam, Performed: Diastolic Blood Pressure satisfies all
Patient Outreach Reports
Pt Outreach: Diabetes HbA1c > 9
Pt Outreach: Diabetes HbA1c > 9
Pt Outreach Encounter
Psychosocial Assessment

HealthLeads Psychosocial Assessment

- In the last 12 months, did you ever eat less than you felt you should because there wasn't enough money for food?
- In the last 12 months, has your utility company shut off your service for not paying your bills?
- Are you worried that in the next 2 months, you may not have stable housing?
- Do problems getting child care make it difficult for you to work or study? (leave blank if you do not have children)
- In the last 12 months, did you skip medications to save money?
- In the last 12 months, have you ever had to go without health care because you didn't have a way to get there?
- Do you ever need help reading hospital materials?
- Are you afraid you might be hurt in your apartment building or house?
- During the last four weeks, have you been actively looking for work?
- If you checked YES to any questions above, would you like to receive assistance with any of these needs?
- Are any of your needs urgent? (For example: I don't have food tonight, I don't have a place to sleep tonight)
Alternative Visit Types – Upcoming Features in Epic

• eVisits with patients through MyChart (questionnaire-based)
• Group Visits documentation tools
Where can you get help?

Contact Information

HealthAdvantage CONNECT
An Envoy from Hawai‘i Pacific Health

Phone Support: 522-4343
Live Support: Monday – Friday 7:30am – 5:30pm
Email: ServiceDesk@HealthAdvantageConnect.com
Million Hearts Resources

- Hypertension Control: Change Package for Clinicians
- Hypertension Control: Action Steps for Clinicians
- Template - Protocol for Controlling Hypertension in Adults
- Tobacco Cessation Protocol
- Cholesterol Management Protocols
Diabetes and Smoking Cessation Resources

- Hawaii Department of Health - Patient Resources
- American Association of Diabetes Educators
  - ADA-recognized and AADE-accredited DSMES Program Sites
  - Algorithm of Care
  - Algorithm Action Steps
- Hawaiʻi Tobacco Quitline
  - Healthcare Providers
  - Community Programs
  - Community Resources
Mountain-Pacific Resources

- **Diabetes Tools and Resources**
  - Fitness and Blood Sugar Trackers Handout
  - Exercise Prescription and Maintenance article

- **eClinical Quality Improvement (eCQI) Quality Methodology**
  - eCQI Resources

- **Cardiac Health Tools and Resources**
  - Cardiac Toolkit
  - Blood Pressure Zone Tool
  - Blood Pressure Poster
  - Blood Pressure Measurement Tips and Tricks
  - Smoking Cessation Butt Out
Hawaii Pacific Health Resources

• HealthAdvantage Connect Service Desk
  - Phone: 808-522-4343
  - Email (non-urgent issues): ServiceDesk@HealthAdvantageConnect.com

• More information about CQM
  – Bulletins on AskIT
How to choose QI projects and get started using PDSA
Plan-Do-Study-Act (PDSA)

- The PDSA quality improvement methodology is an iterative, four-stage problem-solving model used for improving a process
- PDSA is a simple, yet powerful, tool for accelerating change
- Quality improvement is an ongoing cycle with strong emphasis of the use of data for decision making and to verify performance
PDSA, cont.

**Links**

- Mountain-Pacific eCQI PDSA Worksheet template
- Institute for Healthcare Improvement Plan-Do-Study-Act (PDSA) Worksheet

**Diagram**

- **ACT**
  - Plan the next cycle
  - Decide whether the change can be implemented

- **PLAN**
  - Define the objective, questions and predictions. Plan to answer the questions (who? what? where? when?)
  - Plan data collection to answer the questions

- **STUDY**
  - Complete the analysis of the data
  - Compare data to predictions
  - Summarise what was learned

- **DO**
  - Carry out the plan
  - Collect the data
  - Begin analysis of the data
Choose a QI Project

1. Choose your condition/ QI focus
2. Identify the evaluation measures (CQMs) that apply
3. Run the clinical quality measures (CQM) (or other evaluation measure) reports (min. 90-day period) to establish current performance
4. Compare current performance on measures to benchmarks or goals
5. Prioritize list of improvement projects and Identify your first QI project
6. Establish project goals or evaluation metrics/targets

For example: MIPS:

1. Run CQMs chosen for quality category
2. Run Advancing Care Information reports both base and performance measures
3. Compare to benchmark/goals
4. Choose first measure to work on and establish a target goal
Identify Possible Improvements

- Answer this question: “What changes can we make that will result in an improvement to the project goal selected?”
- Brainstorm ideas for possible changes that will ultimately improve the project goal/outcome measure
Identify Possible Changes

- Identify possible EHR functionality changes
  - How can EHR support best practices/protocols?
  - Review staff use and workflows (based on clinical best practices for QI topic)
    - Computer provider order entry (CPOE)
    - Care coordination and transition of care
  - Determine available options, decide on applicability (based on clinical best practices for QI Topic)
    - Clinical Decision Support (CDS)
    - Patient Portal/eSecure messaging
    - Patient Education materials
    - Interfaces
    - Etc.
Review your workflows:

• What is the EHR vendor’s recommended workflow for correct population of the CQM? (ASK YOUR VENDOR!)

• What process do you need to analyze further that will have the biggest impact on the measure outcome?

• Is it electronic, physical or a data flow?
  – Physical - Includes environmental layout of patient room, equipment, devices, supplies, etc.
  – Electronic - How is the work documented? What screens and fields are used?
  – Data -
    ▪ Where does the information documented go?
    ▪ Why does it go there (triggers or reports)?
    ▪ How does it get there (interfaces, uploads, etc.)
Identify the first PDSA (improvement)

- Prioritize your change backlog and choose your first PDSA cycle from the list of possible changes
- Identify a measurable goal for the PDSA cycle
  - Use standard data measures, easily accessible and repeatable
- Establish baseline data, if one is not already available (make step one of plan if needed)
- Determine a target goal for improvement
- Tasks to keep in mind for PDSA plan:
  - Reviewing electronic, data entry and physical workflows, audit reports
  - Leveraging EHR functionality whenever possible
  - Implementing clinical best practices/protocols to support improvement
First QI PDSA Cycle Recommendation

• If data in CQM report is not “accurate,” make your first PDSA cycle about determining accurate electronic workflow, training staff on accurate workflow and validating that data

• That will be your immediate “improvement” and allow all the other functionality in the EHR to work correctly with the structured data
How to choose QI projects and get started using PDSA
CPC+ Example # 2

• Project:
  – Establish care plans for geriatric population

• Project Changes/Improvements
  – Identify population with EHR
  – Implement a care management workflow for empaneled patients to include pre-visit planning, establishing care plans/goals (in EHR), care coordination/follow up and patient education
  – Implement CDS rules to support changes
  – Enhanced communication (secure messaging, phone, etc.)
  – Behavioral health integration
  – Home visits or another alternative visit type
CPC+ Example # 2 Scoring

• eCQMs
  – 2 (Depression Screening), 166 (PHQ-9), 149 (Dementia), 139 (Screening for Falls), 156 (High Risk Rx in Elderly)

• Care Delivery Requirements
  – Define at least one sub population with complex needs and provide additional support
  – Use of care plans to establish and track goals
  – Plan for integrating behavioral health
  – Advanced Care Planning
  – Alternative visit types
Acronyms

- EHR – Electronic Health Record
- CEHRT – Certified Electronic Health Record Technology
- QI – Quality Improvement
- CQM/eCQM – Clinical Quality Measure / electronic Clinical Quality Measure
- PDSA – Plan-Do-Study-Act (iterative, four-stage problem-solving model)
- CDS – Clinical Decision Support
- CPOE – Computerized Provider Order Entry
- HIE – Health Information Exchange
- eCQI - [eClinical Quality Improvement Quality Methodology](#)

[eCQI Resources](#)