2019 Care Coordination Through Patient Engagement

Illinois Health Information Technology Regional Extension Center (ILHITREC)

SUPPORT PROVIDED BY ILHITREC:

The Illinois Health Information Technology Regional Extension Center (ILHITREC), under contract with the Illinois Department of Health and Family Services (HFS), is providing education, outreach, and EHR support to Medicaid providers for the Promoting Interoperability Program. Contact us at info@ILHITREC.org

ILLINOIS DEPARTMENT OF Healthcare and Family Services

ICAHN
Illinois Critical Access Hospital Network

Speaker Biographies

Kerri Lanum, MS, CHC

Kerri Lanum is a Clinical Informatics Specialist at ILHITREC with over 20 years of experience in the healthcare industry. She is an expert in the design and implementation of innovative technologies to support ambulatory practice workflows. She is certified in several EMR Products, a Lean Six Sigma green belt, certified health coach and has a passion for educating providers and medical office staff on how to track their quality data to improve patient care. Kerri is an active member of the Medical Group Management Association (MGMA) and Health Information Management and Systems Society (HIMSS).

Disclaimer

- **The target audience of this presentation is Eligible Providers, but some references may be made related to Eligible Hospitals.**
- This webinar is based on official guidance provided by the Centers for Medicare and Medicaid Services (CMS) and the Office of the National Coordinator (ONC), experiences from ILHITREC, and other Regional Extension Centers.
- This presentation was prepared as a tool to assist providers enrolled in the Medicaid Promoting Interoperability program administered by CMS. The ultimate responsibility for compliance, submission and response to any remittance from CMS rests with the provider. Medicare policy changes frequently. It is highly recommended that providers and their designee review rules and regulations frequently.
- The focus of this presentation is **Stage 3 2019 Reporting Requirements.** The content applies to the Medicaid Promoting Interoperability program through CMS and the ONC.

Acronyms

- CEHRT-Certified Electronic Health Record Technology
- CQM-Clinical Quality Measure
- eCQM- Electronic Clinical Quality Measure
- EHR-Electronic Health Record
- EP- Eligible Professional
- MIPS- Merit Based Incentive Payment System
- MU-Meaningful Use
- NQF- National Quality Forum
- QPP-Quality Payment Program
- QRDA- Quality Reporting Document Architecture
- PI- Promoting Interoperability
- API-Application Programming Interface
- CDR- Clinical Data Registry
- PFAC-Patient and Family Advisory Council

CMS Acronyms

2019 Program Reminder

- ✓ Pre-approvals for 2019 patient volume will begin being accepted in June 2019.

Patient Volume Pre-Approval

Patient Volume Pre-Approval Process

✓ Contact HFS @ hfs.ehrincentive@Illinois.gov

Provide the following information:

TIN =

Group or individual numbers?

Provider type: (physician, hospital, dentist)

Date Range (either from the previous calendar year or previous 12 months from today's date)=

Straight Medicaid (only traditional Medicaid & All Kids) =

(count ALL encounters where straight Medicaid is the primary, secondary, or tertiary coverage even if Medicaid paid $0.00 and Medicaid/Medicare crossovers).

Medicaid Managed Care =

Total Encounters for all payees =

Incentive Payments

There are still Incentive payments $$$ available until 2021

First Year	Total	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021
2011	$63,750	21,250	8,500	8,500	8,500	8,500	8,500					
2012	$63,750		21,250	8,500	8,500	8,500	8,500	8,500				
2013	$63,750			21,250	8,500	8,500	8,500	8,500	8,500			
2014	$63,750				21,250	8,500	8,500	8,500	8,500	8,500		
2015	$63,750					21,250	8,500	8,500	8,500	8,500	8,500	
2016	$63,750						21,250	8,500	8,500	8,500	8,500	8,500

Learning Objectives

Discuss Why Patient Engagement Leads to Better Outcomes

Define the Care Coordination Through Patient Engagement Measure

Answer Program FAQ

Patient Activation vs. Patient Engagement

Patient activation emphasizes patients' willingness and ability to take independent actions to manage their health and care. This definition equates patient activation with understanding one's role in the care process and having the knowledge, skill, and confidence to manage one's health and health care. Activation differs from compliance, in which the emphasis is on getting patients to follow medical advice.

Patient Engagement is a broader concept that includes activation; the interventions designed to increase activation; and patients' resulting behavior, such as obtaining preventive care or engaging in regular physical exercise. The focus on activation and engagement rather than compliance recognizes that patients manage their health on their own the vast majority of the time, making decisions daily that affect their health and costs.

Evidence For Patient Engagement

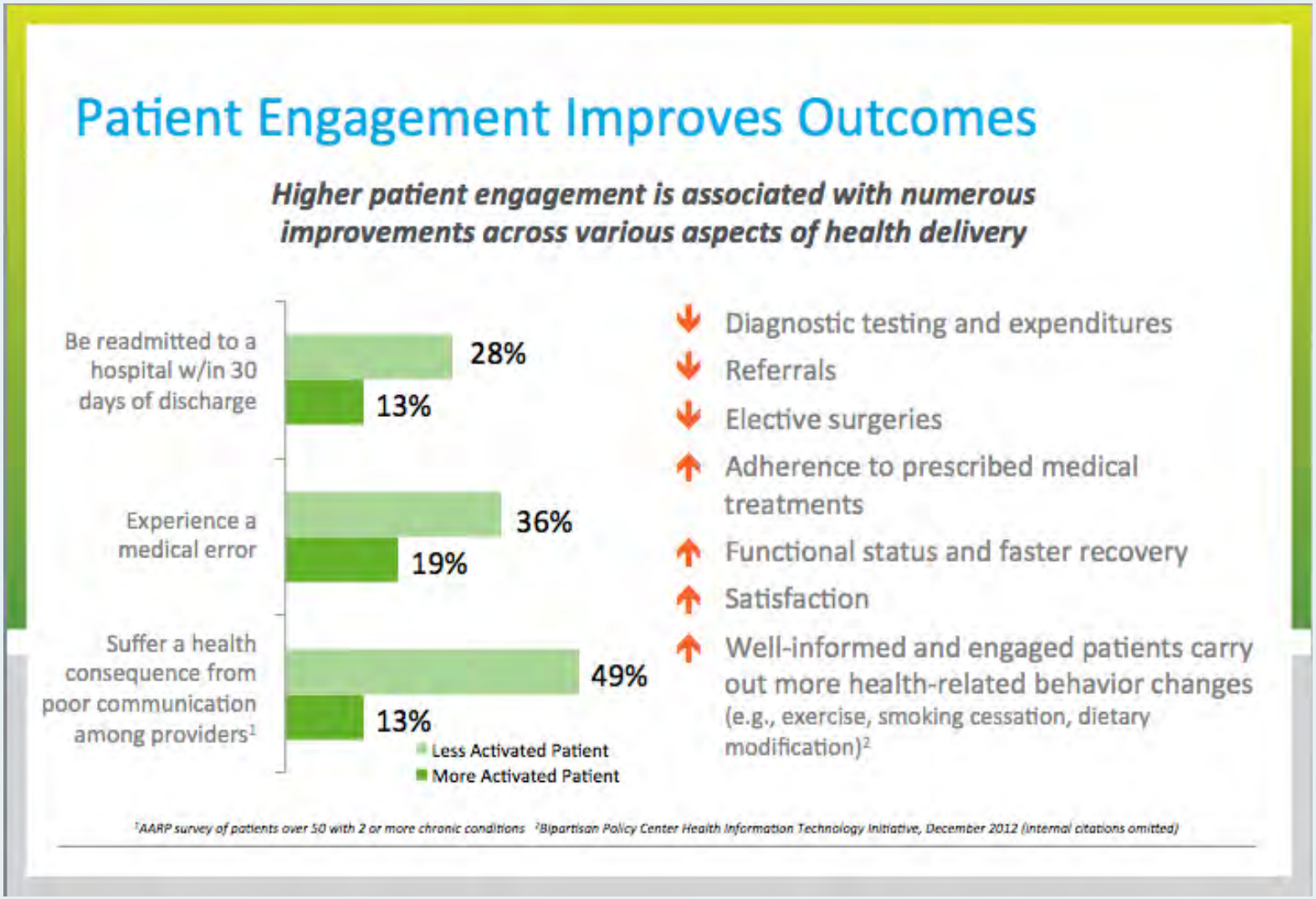
Patient Engagement = Better outcomes

Patient Portals and Patient Engagement: A State of the Science Review

What The Evidence Shows About Patient Activation: Better Health Outcomes And Care Experiences

Health IT Patient Engagement Playbook

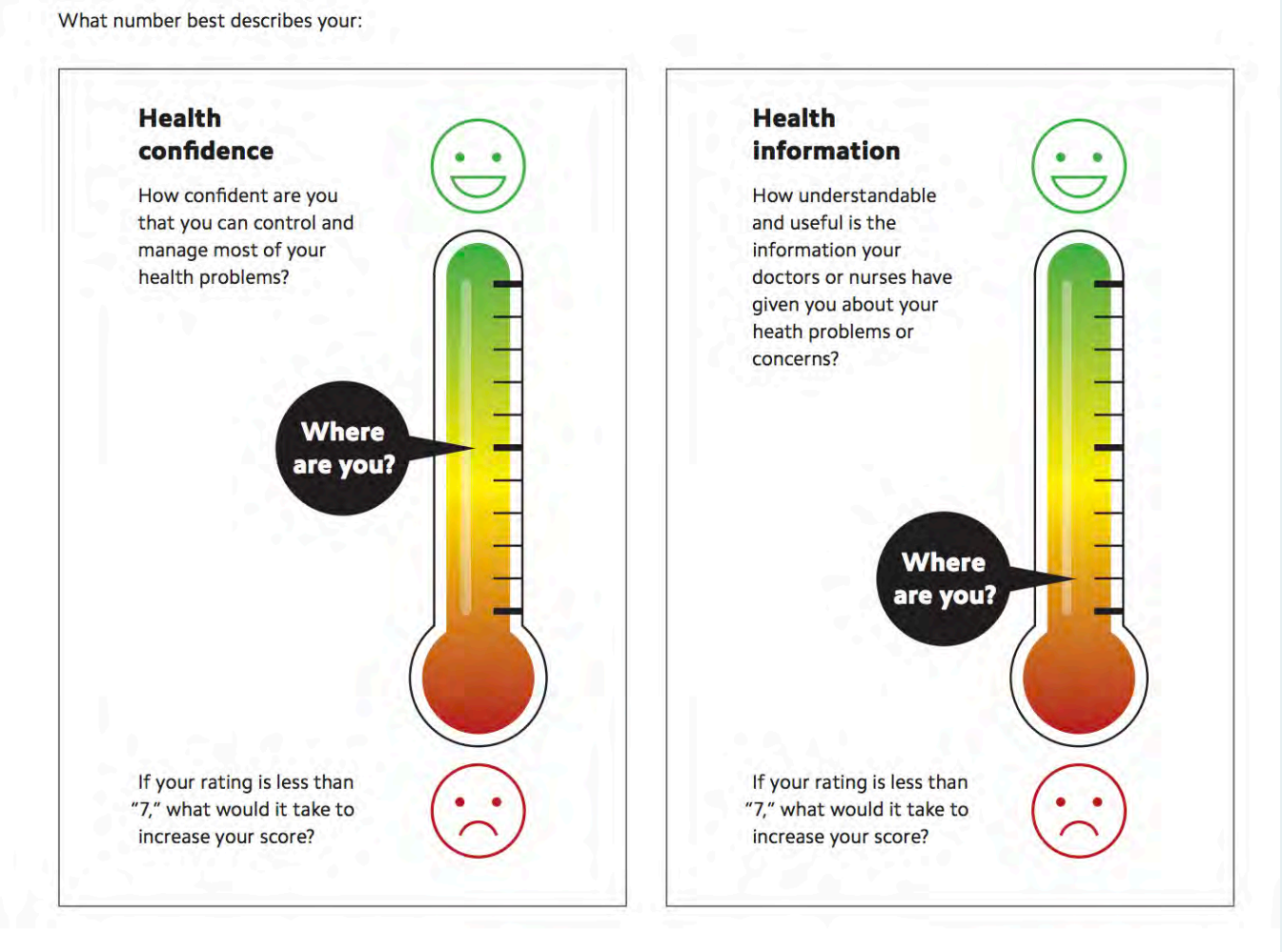
Evidence For Patient Engagement



How can we Engage our Patients?

Measuring Patient Activation

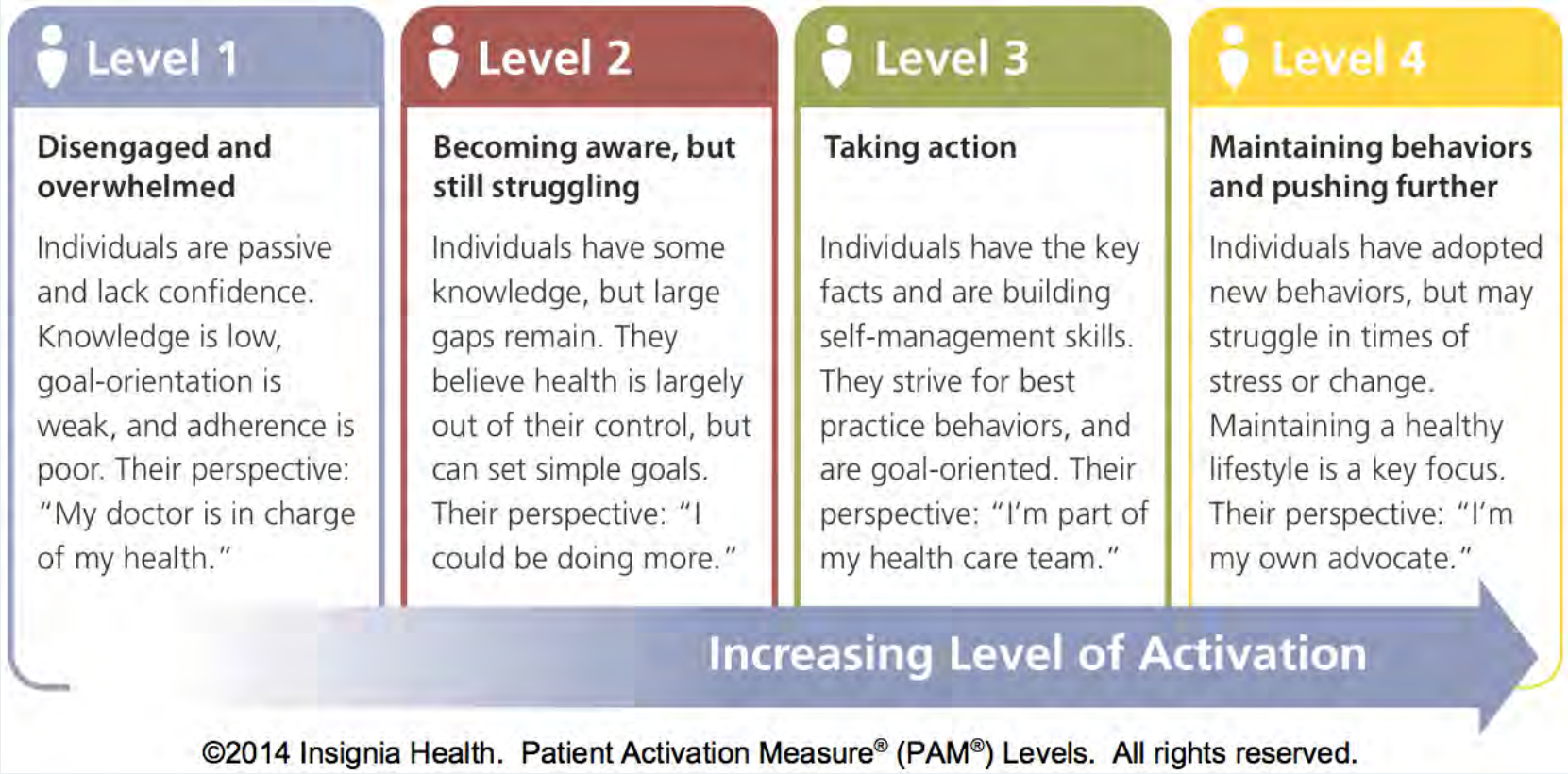
[John Wasson, MD, and Eric A. Coleman, MD, MPH research and publication]



How can we Engage our Patients?

Patient Activation Measurement (PAM) Tool

PAM Tool



How can we Engage our Patients?

Tools/Strategies to Increase Patient Engagement

- **Patient Portals**
- **Health Apps**
- Patient Family Advisory Councils (PFAC)
- Shared Decision Making

Prepare to be Engaged

Stage 3

Objective Measures	Stage 3
Objective 1: Protect Patient Information	Perform Security Risk Analysis
Objective 2: E-Prescribing	>60%
Objective 3: Clinical Decision Support (CDS)	5 interventions related to 4 or more CQMs drug-drug + drug-allergy alerts
Objective 4: CPOE Meds/Labs/Rads	>60%/>60%/>60%
Objective 5: Patient Electronic Access with Patient Education	>80% /> 35%
Objective 6: Coordination of Care	>5% VDT/>5% Messaging/>5% pt. generated health info
Objective 7:Health Information Exchange	>50% send summary of care/>40% receive summary of care/> 80% clinical reconciliation for new patients
Objective 8: Public Health Reporting	Report on 2 out of 5 measures

Stage 3 measure specifications

Changes from Stage 2 to Stage 3

	2018 Medicaid PI Modified Stage 2	2018 Medicaid PI Stage 3
Security Risk Analysis	Required	Required
E-Prescribing	Required more than **50%** Exclusion if denom <100	Required more than 60% Exclusion if denom <100
Clinical Decision Support	Required 5 alerts related to 4 CQMs + drug-drug & drug-allergy interactions	Required 5 alerts related to 4 CQMs + drug-drug & drug-allergy interactions
CPOE – Med, Lab & Radiation Orders	Required Meds more than 60%, Labs/Rads more than 30% Exclusion if denom <100	Required more than 60% Exclusion if denom <100
Medication Reconciliation	Required more than 50%	Removed
Patient Electronic Access	Required more than 50%	Required more than 80%
Patient Education	Required more than 10%, does not have to be electronic	Required more than 35%, has to be electronic
View, Download and/or Transmit	Required more than 5%	Required more than 5%
Secure Messaging	Required more than 5%	Required more than 5%
Patient-Generated Health Data	Not required	Required more than 5%
Summary of Care	Required more than 10% send Exclusion if denom <100	Required more than 50% send and more than 40% receive Exclusion if denom <100
Clinical Reconciliation	Not required	Required more than 80%
Public Health Reporting	Required 2 of 3 options	Required 2 of 5 options

Changes from Stage 2 to Stage 3

	2018 Medicaid PI Modified Stage 2	2019 Medicaid PI Stage 3
View, Download and/or Transmit	Required more than 5%	Required more than 5%
Secure Messaging	Required more than 5%	Required more than 5%
Patient-Generated Health Data	Not required	Required more than 5%

Objective 6: Coordination of Care

Measure 1: **> 5%** of all unique patients (or their authorized representatives) seen by the eligible professional (EP) actively engage with the EHR

1) View, download or transmit to a third party their health information; **or**
2) Access their health information through the use of an Application Programming Interface (API) that can be used by applications chosen by the patient and configured to the API in the provider's CEHRT; or
3) A combination of (1) and (2)

Measure 2 : **> 5%** of all unique patients seen by the EP during the PI reporting period, a secure message was sent using the electronic messaging function of CEHRT to the patient (or the patient authorized representative), or in response to a secure message sent by the patient or their authorized representative.

Measure 3: Patient generated health data or data from a nonclinical setting is incorporated into the CEHRT for **>5%** of all unique patients seen by the EP during the PI reporting period.

Exclusions: Any EP who:

1) No office visits during the PI reporting period.

2) Any EP that conducts <50% of his or her patient encounters in a county that does not have 50% or more of its housing units with 4Mbps broadband availability according to the latest information available from the Federal Communications Commission (FCC) on the first day of the PI reporting period.

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API- APIs are messengers or translators that work behind the scenes to help software programs communicate with one another. If you have ever used a web-based application or a mobile "app" on your computer, smartphone, or tablet to purchase a flight or pay a bill, you've probably used an API.

API Education module

Objective 6: Coordination of Care

Examples of Apps with APIs

Apple Health

CMS- ibluebutton

Objective 6: Coordination of Care

Measure 2 : **> 5%** of all unique patients seen by the EP during the PI reporting period, a secure message was sent using the electronic messaging function of CEHRT to the patient (or the patient authorized representative), or in response to a secure message sent by the patient or their authorized representative.

Benefits of secure electronic messaging

-Avoid telephone tag, which can lead to both miscommunication and communication delays

-Address routine health issues more efficiently, so you can dedicate more time to patients who need in-person care

-Have support staff to triage messages, so that clinicians only need to weigh in as necessary

Objective 6: Coordination of Care

Measure 2 : **> 5%** of all unique patients seen by the EP during the PI reporting period, a secure message was sent using the electronic messaging function of CEHRT to the patient (or the patient authorized representative), or in response to a secure message sent by the patient or their authorized representative.

Secure Electronic Messaging for Improved Preventive Screenings

Preventive Screening Reminder

Flu activity is picking up! Please take the time for you and your family to get their flu shot to protect against the flu if you haven't already done so.

Flu vaccination can reduce flu illnesses, doctors' visits, and missed work and school due to flu, as well as prevent flu-related hospitalizations.

Objective 6: Coordination of Care

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Secure Electronic Messaging for Improved Quality Measure Performance

CMS eCQM ID	NQF #	Measure Title	Measure Description	Numerator Statement	Denominator Statement	Quality Domain	Meaningful Measure Area	Quality#
CMS122v7	0059	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	Patients whose most recent HbA1c level (performed during the measurement period) is >9.0%	Equals Initial Population: Patients 18-75 years of age with diabetes with a visit during the measurement period	Effective Clinical Care	Management of Chronic Conditions	001

Objective 6: Coordination of Care

Measure 3: Patient generated health data or data from a nonclinical setting is incorporated into the CEHRT for **>5%** of all unique patients seen by the EP during the PI reporting period.

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Tips for Clinicians

Clinicians can use patient-generated health data to:

- Show how a patient is doing between visits
- Illustrate a patient's health and behavior over time
- Inform strategies for preventive care and chronic disease management

Portals can streamline data collection by giving patients a platform for securely sharing information and completing online questionnaires. Clinicians can use the portal to send patients reminders to submit data and to follow up with patients as needed.

Tips for Practice Administrators

Take these steps to integrate patient-generated health data into your practice:

- Talk to staff about how patient-generated health data can improve care and efficiency
- Assess what data you're already gathering and what additional data would be valuable
- Develop policies and procedures, like when to accept data and who will review them
- Educate patients and families about the value of and expectations for sharing patient-generated health data
- Start small — for example, by launching a pilot to collect symptoms for patients managing a chronic disease — and make changes as needed

Objective 6: Coordination of Care

Additional Considerations:

EPs must attest to all three measures and must meet the thresholds for at least **two** measures to meet the objective.

Medicaid PI FAQs

Do we have to Report on Stage 3 measures in 2019?

Yes

Medicaid PI FAQs

Does my EHR have to be 2015 Certified to attest in 2019?

Yes

What is the Reporting Period for Objective Measures for 2019?

90 days

Medicaid PI FAQs

What is the reporting Period for Clinical Quality Measures for 2019?

For the EHR reporting period in 2019, providers will attest to a full year of CQM reporting unless it is their first year of MU reporting then it can be any continuous 90 day period in that calendar year.

Upcoming ILHITREC Deep Dive Webinars

- Jun 11th noon Health Information Exchange
- Jul 16th noon Public Heath Reporting

More information and registration links are available on ILHITREC's website at http://www.ilhitrec.org/ilhitrec/webinars.shtml.

Educational Resources

ILHITREC
info@ILHITREC.org or **http://www.ILHITREC.org**

Healthit.gov
https://www.healthit.gov/playbook/pe/introduction/

Health Information Management Systems Society
http://www.HIMSS.org

EHR Vendor

Additional References

- Medicaid PI Toolkit
- 2019 IPPS Final Rule
- CMS Promoting Interoperability Program
- Motivational Interviewing
- Comparing Stage 2 and Stage 3 Infographic
- IDPH Public Health Objectives Registration
- ICARE- Illinois Immunization Registry

Thank you!

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NIU Northern Illinois University

Questions?

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