Hidden dangers in Electronic Clinical Quality Measures (eCQMs)

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Introduction

The drive toward value-based care is prompting healthcare organizations to focus on demonstrating quality like never before. This growing requisite for payment from the Centers for Medicare and Medicaid Services (CMS) creates many new risks and challenges, but perhaps the most complex is electronic Clinical Quality Measures (eCQMs). eCQMs use structured data from electronic health records (EHRs) and/or quality management systems to report core measures performance directly to CMS and The Joint Commission.

While most hospitals have placed great focus on Meaningful Use and the Hospital Value-Based Purchasing (VBP) Program as threats to their bottom line, many organizations are not aware that eCQM performance affects their annual payment update (APU), which is up to 1 percent of their total Medicare reimbursement. When organizations are operating on very thin margins, a hit to the APU can be significant. For the average hospital, 1 percent puts approximately $1.3 million at risk.[1]

Why are eCQMs important?

- **Impact to Medicare reimbursement.** eCQMs are required for the CMS Inpatient Quality Reporting Program (IQR). Failure to report eCQMs will impact the hospital's CMS APU, which is cumulative and compounds exponentially year over year.
- **Public reporting.** eCQMs are not publicly reported in the first year, but that changes in subsequent years. Healthcare organizations could find poor quality scores available on the Internet soon. Patients are increasingly engaged in their care and rely on published quality data to evaluate providers.
- **Payor contract negotiations.** Employers and commercial payers utilize quality measures to negotiate contracts and reimbursement with providers.
- **Organizational reputation and recruitment.** Providers strive to deliver quality care, and poor quality scores can negatively impact physician engagement and market expansion goals.
- **The Joint Commission accreditation.** Building accurate eCQM reporting capabilities is commiserate with ensuring that hospitals remain in good standing with The Joint Commission.

The rising tide of electronic quality reporting

CMS has raised the stakes on using EHR technology to validate that quality patient care has been provided. Until recently, most core measures reporting was completed through chart-abstracted measures. eCQM reporting was voluntary, but that all changed in 2016. And beginning in 2017, eCQM requirements exceeded that of chart-abstracted measures.

This shift in specifications is fraught with hidden risk as eCQMs represent a much more challenging standard to validate passing the core measures.

From manual to machine

Documentation sources for chart-abstracted measures can include paper, electronic, structured or unstructured data (e.g., free-field text within the EHR). On the other hand, eCQM submissions are gathered only through what the clinician electronically documents within the EHR's structured data field at the point of care. That information is then exported into a specified file format (QRDA I), which is then sent to QNET (CMS).

With the former, hospital quality department abstractors identify and gather documentation from various patient record sources if baseline care practices took place for a particular core measure, and then submit the information manually to CMS. With the latter, passing or failing a core measure is based purely on automation—a human-free, technology-to-technology submission. Without the benefit of chart abstractors for testing, no machine, unless it is continually fine-tuned, is going to be able to capture the same level of information equal to that of human intelligence.

EHR vendors are required by law to support eCQMs as a condition of Meaningful Use. As a result, many hospitals have assumed their EHRs can handle the new eCQM submission requirements, but this can prove costly as market research and literature point to EHR deficiencies when it comes to capturing this data appropriately. Extending beyond the risks of removing human touch, this white paper explores the hidden dangers of eCQMs and offers proven strategies to overcome them.

1 Assuming average gross Medicare revenue is $139,603,639 for all nongovernment hospitals nationwide.

Charting where the dangers lurk

Although EHR vendors are required by law to meet eCQM requirements, it's common to find that these systems lack proper formatting capabilities. Most EHRs were developed to capture documentation for reimbursement and, in many instances, physician satisfaction. There's great risk that these systems are not sufficient for the full automation of the eCQM data extraction process. Without proper testing, it is difficult to substantiate that the data submission is meeting requirements.

– **The human factor.** Human nature always presents risk. No matter how many safeguards and warning flags are implemented (e.g., how often the EHR prompts for documentation in a certain field), there are clinicians who will find workarounds or gravitate toward free-text notes, dictations or scanned PDFs rather than populate the structured data elements needed to complete the QRDA I file. There are multiple reasons this occurs, including the fact that doctors are forced to learn multiple systems.

– **Workflow.** The hospital's clinical workflows and the use of clinical terminology can be misaligned with eCQM specifications. Many data elements of the patient record could be documented and stored in more than one location within the hospital. For example, when an order is generated or placed and when the patient leaves the facility may be recorded in several different departments or possibly multiple EHRs.

– **Disparate EHR technology.** Related to workflow, uncertainty is compounded by multiple EHRs. Given the pace of hospital mergers and consolidations, many integrated delivery networks (IDNs) have only recently come together. Although operating under one brand name, most IDNs house multiple EHRs, or possess the same vendor's EHR but are on different versions of it. A common example is a technology environment with different EHRs in the perinatal area and the emergency department. Aggregating data across the system in these situations is very problematic. Plus, the QRDA I files must be tested for each EHR. It also means the current EHR may not be the long-term solution, yet the eCQM reporting requirements will continue to increase in the interim.

– **Transition costs.** Most hospitals have not calculated the cost to implement plans to build eCQM reporting capabilities. Accepting payment reduction may prove costlier than implementing and reporting eCQMs accurately when you consider the investment associated with updating measure logic in the EHR, along with the soft costs of staff education and training.

Charting the course to avoid hidden dangers

There are proven paths for navigating through the risks associated with eCQM reporting. Strategies include initiatives that create insight into data mapping deficiencies, programs to obtain the new resource and capability requirements, and efforts that develop validating data to reach hospital board and quality department consensus on the most effective transition process.

– **Validate early and often.** Although hospitals have the option to report core measures performance on a quarterly, half-year or annual reporting basis, make sure your organization is not taken by surprise. Put a program in place to start collecting data as soon as possible to evaluate performance before transmitting QRDA I files, as well as aggregated QRDA I file error reports. Pursue engaging third-party resources with the appropriate experience and the right set of validation tools to monitor and test the accuracy of data reported in the QRDA I files. When evaluating how to build out your validation capabilities, keep in mind that there are new, web-based solutions available to provide next-day results versus traditional tools that may take weeks or months in turnaround time. In addition, make sure your capabilities extend beyond pass or fail monitoring to provide insight into the source of errors.

– **Compare manual and automated extraction data.** Conduct an "apples to oranges" comparison of manual chart abstractions against your eCQMs submissions, along with the subsequent QRDA I file error report, to reveal the missing pieces. With this information in hand, there is an opportunity to go back to the EHR implementation team to demonstrate why data remapping is needed. Any discrepancies revealed in comparison analysis can be particularly empowering in discussions with the hospital board and the medical quality staff. For example, if there is a core measure failure, you have documentation to prove that quality patient care hasn't changed; it is the result of EHR technology not capturing everything that is needed. It's important to keep in mind that as eCQM requirements increase over the coming years, a concurrent rising tide of experienced abstractor resources will be needed to validate that the chart-abstracted data is aligning with what the eCQMs have pulled.

– **Query your EHR vendor.** Engage in discussions with your EHR vendor to confirm that the current version of your EHR is certified and validated to support the creation of a QRDA I file. For some organizations, this step may prove difficult because the EHR vendor relationship lies with the IT department and not the quality team. Possessing proof that there are discrepancies

between the eCQM reporting and abstracted chart measures can be powerful leverage to move vendor discussions forward. Some of the critical questions to ask your EHR vendor and IT department leaders include:

- How can the organization validate the QRDA I files prior to submission to ensure accuracy?
- Is our EHR technology able to provide a QRDA I file error report?
- What is the corrective course of action if the technology cannot validate the QRDA I files prior to submission and errors exist?

– **Turn to your core measures vendor.** If you discover that your EHR is not certified for eCQMs and/or the EHR's current data mapping is not creating an accurate QRDA I file, a great option lies in partnering with your core measures vendor. It's very likely that expanding the core measures data dictionaries to capture the required information presents a more productive and less challenging pathway to meeting eCQM reporting.

Choosing the right partner for eCQM success

At Nuance, our mission is to help clients improve reimbursement by enabling fast, accurate and easy capture of patient data required by CMS for full Medicare annual payment updates and The Joint Commission accreditation. As regulatory agencies continue to emphasize reporting on clinical outcomes, we offer experts and powerful web-based, decision-support and transmission tools to help organizations demonstrate how they are providing quality care. Our unique approach and proven outcomes set us apart by:

– Integrating clinical and administrative data for abstraction, identifying missing eCQM data in real time;

– Identifying and correcting QRDA I file errors prior to submission of daily core measures processing and performance dashboard updates;

– Offering true concurrent abstraction and real-time trending;

– Supporting all CMS and The Joint Commission core measures needs across care settings; and

– Automating reporting to CMS, The Joint Commission, registries and state initiatives.

Contact Nuance to learn how our customizable, easy-to-use solutions can help your organization meet the challenge of immediate and long-term core measures requirements. Visit nuance.com or call 1-877-805-5902 to speak to a clinical documentation specialist today.

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