♠Measure #124: HIT - Adoption/Use of Health Information Technology (Electronic Health Records)

DESCRIPTION:
Documents whether provider has adopted and is using health information technology. To qualify, the provider must have adopted a qualified electronic medical record (EMR). For the purpose of this measure, a qualified EMR can either be a Certification Commission for Healthcare Information Technology (CCHIT) certified EMR or, if not CCHIT certified, the system must be capable of all of the following:

- Generating a medication list
- Generating a problem list
- Entering laboratory tests as discrete searchable data elements

INSTRUCTIONS:
This measure is to be reported at each visit occurring during the reporting period for patients seen during the reporting period. There is no diagnosis associated with this measure. This measure may be reported by clinicians who have adopted and are using health information technology.

This measure is reported using G-codes:
CPT E/M codes, CPT service codes, CPT procedure codes, HCPCS D-codes and HCPCS G-codes are used to identify patients who are included in the measure's denominator. G-codes are used to report the numerator of the measure.

When reporting the measure, submit the appropriate denominator code(s) and the appropriate numerator G-code.

NUMERATOR:
Patient encounter documentation substantiates use of certified/qualified EMR

Definitions:
Health Information Technology (HIT) – A system that incorporates both computer hardware and software that deals with the storage, retrieval, sharing, and use of health care information, data, and knowledge for communication and decision making.
CCHIT – The Certification Commission for Healthcare Information Technology – an independent, nonprofit organization that has been recognized by the federal government as an official certification body for electronic health record products.
Discrete searchable data elements – Laboratory data that can be recorded in predefined fields in predefined formats within the EMR that allow for reports to be generated, such as trends of a specific element over time. This cannot be easily done if data is entered via a free text format or by merely scanning a report into the EMR.

Numerator Coding:
Encounter Documented Using CCHIT Certified or Qualified EMR
G8447: Patient encounter was documented using a CCHIT certified EMR
OR

G8448: Patient encounter was documented using a non-CCHIT certified EMR. To qualify, the system must be capable of all of the following:

- Generating a medication list
- Generating a problem list
- Entering laboratory tests as discrete searchable data elements

OR

Encounter not Documented Using CCHIT Certified or Qualified EMR for System Reasons

G8449: Patient encounter was not documented using an EMR due to system reasons such as, the system being inoperable at the time of the visit. Use of this code implies that an EMR is in place and generally available

DENOMINATOR:

All patients aged 18 years and older

Denominator Coding:

A CPT service code, CPT E/M code, HCPCS D-code or HCPCS G-code is required to identify patients for denominator inclusion.

CPT service codes, CPT E/M codes, HCPCS D-codes or HCPCS G-codes: 90801, 90802, 90804, 90805, 90806, 90807, 90808, 90809, 92002, 92004, 92012, 92014, 96150, 96151, 96152, 97001, 97002, 97003, 97004, 97750, 97802, 97803, 97804, 98940, 98941, 98942, 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245, D7140, D7210, G0101, G0108, G0109, G0270, G0271

RATIONALE:

The need for clinical information systems to provide high-quality, safe care is a well recognized fact, as publicized by Dr. Ed Wagner in his Chronic Care Model. A comprehensive clinical information system can enhance the care of individual patients by:

- Providing timely reminders about needed services
- Summarizing data to track and plan care
- Identifying groups of patients needing additional care
- Facilitating performance monitoring and quality improvement efforts

While it is preferable to encourage adoption of CCHIT certified EMRs, it became apparent during measure field testing that CCHIT certified EMRs are not currently available for all provider settings and specialty groups that may report this measure. Therefore, additional numerator coding was added to enable providers who have adopted a non-CCHIT certified product, which meets a set of standards, to also report this measure. The following is an excerpt taken from the CCHIT website:

The 2006 Ambulatory EHR Criteria represent basic requirements that the Commission and its Workgroups believe are appropriate for many common ambulatory care settings. CCHIT acknowledges that these Criteria may not be suitable for settings such as behavioral health, emergency departments, or specialty practices and our current certification makes no representation for these. Purchasers should not interpret a lack of CCHIT Certification as being of significance for specialties and domains not yet addressed by CCHIT Criteria.

Evidence Supporting the Criterion of the Quality Measure:

Overall Evidence Grading: SORT Strength of Recommendation B: considerable patient-oriented evidence, i.e., re: better patient care management, higher patient satisfaction, reduction of adverse drug events, better quality performance, and improved patient safety, but not consistently high quality evidence

Committee on Quality Health Care in America (2001). Crossing the Quality Chasm: A new health system for the 21st century. Washington, D.C., National Academy Press.

This report explains the difficulty managing a patient's care using a written medical record, which can be cumbersome to navigate through, as well as illegible. Not only would an EMR be consistent and legible, it can provide reminders and prompts, allowing better management of patient care. In addition, patients who can access their provider using e-mail can have their needs met more quickly and cost effectively.

Study quality level 2 (limited-quality patient-oriented evidence)

Hillestad, R., et al. (2005). "Can electronic medical record systems transform health care? Potential health benefits, savings and costs." Health Affairs 24(5): 1103-1117.

This article concludes that two-thirds of the approximately 8 million adverse drug events that occur in the outpatient setting would be avoided through the widespread use of computerized physician order entry (CPOE).

Study quality level 2 (limited-quality patient-oriented evidence)

Jha, A. K., et al. (2003). "Effect of the transformation of the Veterans Affairs Health Care System on quality of care." NEJM 348(22): 2218-2227.

The Veterans Health Administration medical system uses an EMR system-wide. The authors attribute the VHA's superior quality performance in part to "an emphasis on the use of information technology."

Study quality level 2 (limited-quality patient-oriented evidence)

Middleton, B. (2005). The value of health information technology in clinical practice. Pennsylvania eHealth Initiative, Harrisburg.

This article highlights the impact that various components of HIT and EMR will have on improving patient safety. Additionally, Dr. Middleton enumerates the cost benefits of ambulatory computerized physician order entry (ACPOE).

Study quality level 2 (limited-quality patient-oriented evidence)

Mitchell, E., Sullivan, F. (2001). "A descriptive feast but an evaluative famine: systematic review of published articles on primary care computing during 1980-1997." BMJ 322(7281): 279-282.

This older systematic review documents the value of using ECI in a variety of primary care situations.

Study quality level 2 (limited-quality patient-oriented evidence; systematic review but older)