Preparing For The Transition To eCQM Reporting

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Objectives

- Differentiate eCQMs and core measures (chart-abstracted)
- Describe differences between TJC and CMS eCQM reporting
- Overview of Meaningful Use proposed rules
- Assess organizational readiness for transition to eCQM reporting
- Review transition ideas and how Truven Health can assist
Journey to eCQM Reporting

- What is your involvement in eCQM reporting?
- Where is your organization at on this journey?
- What department coordinates the Meaningful Use (MU) effort?
- What products are used to meet the MU quality reporting measures?
- Reporting by attestation vs. electronic submission of patient level data?
- Are MU measures results accurate?
CQM Evolution and Electronic Reporting Timeline

- **2002** – Core Measures Program starts with 2 measure sets...
- **2009** – American Recovery & Reinvestment Act (ARRA)
- **2011** - EHR Incentive Program Implementation Begins
  - Requires clinical quality measures reporting using eCQMs
  - Requires aggregate reporting of eCQM results to CMS (attestation)
- **2012/13** – CMS Pilot to test electronic reporting of eCQMs
- **2014** – TJC pilot to test electronic reporting of eCQMs
- **2014** – CMS offers voluntary electronic reporting of eCQMs
- **2015** – TJC offers voluntary electronic reporting of eCQMs
- **2016** – CMS proposes (and finalizes) requirement to report eCQMs electronically for Hospital IQR Program
- **2018** – CMS proposes to require electronic reporting of eCQMs for MU
eCQMs vs. Chart-abstracted Quality Measures

- Chart–abstracted measures (Core Measures)
  - Done by nurse, based on detailed notes for abstraction for every data element collected
  - Managed by Quality Department

- eCQMs (Electronic Clinical Quality Measures)
  - Designed to eliminate need to abstract data
  - Data must be obtained directly from EHR, no room for interpretation, no human review
  - Requires involvement of IT resources

- Measures seem the same - names match but:
  - Specifications are different
  - Data definitions are different
  - Algorithms are different
eCQM Terms of Art

- EHR Incentive Program
  - Government program that provides incentives for using (or penalties for not using) EHRs in a meaningful manner

- CEHRT (Certified Electronic Health Records Technology)
  - The EHRs to be used under the above program have to be certified

- eCQM – electronically specified clinical quality measures
  - SNOMED – Terminology used to represent diagnosis and procedures (broad use – more than ICD-9 codes) in the EHR
  - RxNorm – Terminology used to represent medications in the EHR
  - LOINC - Terminology used to represent labs in the EHR
**eCQM Terms of Art**

- **HQMF**– Health Quality Measures Format
  - The HL7 format used to define the specifications and algorithms used to calculate the eCQMs

- **Reporting (Submission) Methods**
  - **Attestation** – Manually reporting aggregate quality measure results to CMS to meet MU requirements
  - **Electronic Reporting** – submitting patient level XML files to CMS and TJC to meet MU and TJC accreditation requirements

- **QRDA** – Quality Reporting Document Architecture
  - XML file format that includes data for one patient used to report to CMS and TJC under the electronic reporting option
Comparing a Core Measure to an eCQM - VTE-1

- Measure Information Form (Core Measure)

- Measure: VTE-1: Venous Thromboembolism Prophylaxis

- Description: This measure assesses the number of patients who received VTE prophylaxis or have documentation why no VTE prophylaxis was given the day of or the day after hospital admission or surgery end date for surgeries that start the day of or the day after hospital admission.
VTE-1 (VTE Prophylaxis) - Core Measures

- Data Elements to be abstracted for the numerator:
  - *Reason for No VTE Prophylaxis – Hospital Admission*
  - *Reason for Oral Factor Xa Inhibitor*
  - *Surgery End Date*
  - *Surgical Procedure*
  - *VTE Prophylaxis*
  - *VTE Prophylaxis Date*
Data Element: **Reason for Oral Factor Xa Inhibitor**

**Data Element Name:** Reason for Oral Factor Xa Inhibitor

**Collected For:** CMS/The Joint Commission: STK-1, VTE-1

**Definition:** Documentation why Oral Factor Xa Inhibitor was administered for VTE prophylaxis.

**Suggested Data Collection Question:** Is there physician/APN/PA documentation why Oral Factor Xa Inhibitor was administered for VTE prophylaxis?

**Format:**
- **Length:** 1
- **Type:** Alphanumeric
- **Occurs:** 1

**Allowable Values:**
- **Y (Yes):** There is physician/APN/PA documentation why Oral Factor Xa Inhibitor was administered for VTE Prophylaxis.
- **N (No):** There is no physician/APN/PA documentation why Oral Factor Xa Inhibitor was administered for VTE Prophylaxis, OR unable to determine from the medical record documentation.

**Notes for Abstraction:**
- Only acceptable reasons identified in the list of inclusions. No other reasons will be accepted.
- History of atrial fibrillation/flutter or current finding of atrial fibrillation/flutter, select “Yes.”
- History of hip or knee replacement surgery, select “Yes.”
- When conflicting information is documented in the medical record, select “Yes.”
- History of treatment for venous thromboembolism or current treatment for venous thromboembolism, select “Yes.”

**Suggested Data Sources:**
**PHYSICIAN/APN/PA DOCUMENTATION ONLY IN THE FOLLOWING ONLY ACCEPTABLE SOURCES:**
- Anesthesia record
- Consultation notes
- Emergency Department record
- History and physical
- Operative Note
- Physician orders
- Progress notes
- Risk assessment form
- Transfer sheet

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Specifications Manual for National Hospital Inpatient Quality Measures
Discharges 01-01-15 (1Q15) through 09-30-15 (3Q15) 1-353

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VTE-1: Venous Thromboembolism Prophylaxis

Diagram showing the algorithm with decision points and flow arrows indicating the measures and conditions for each step.
VTE-1 – eCQM – Data Elements (Partial List)

- "Diagnosis, Active: Hemorrhagic Stroke" using "Hemorrhagic Stroke Grouping Value Set (2.16.840.1.113883.3.117.1.7.1.212)"

- "Device, Applied: Graduated compression stockings (GCS)" using "Graduated compression stockings (GCS) SNOMEDCT Value Set (2.16.840.1.113883.3.117.1.7.1.256)"

- "Medication, Administered: Low Molecular Weight Heparin for VTE Prophylaxis" using "Low Molecular Weight Heparin for VTE Prophylaxis RXNORM Value Set (2.16.840.1.113883.3.117.1.7.1.219)"

- "Procedure, Performed: General Surgery" using "General Surgery Grouping Value Set (2.16.840.1.113883.3.117.1.7.1.255)"

- "Laboratory Test, Result: INR" using "INR LOINC Value Set (2.16.840.1.113883.3.117.1.7.1.213)"
VTE-1 – eCQM – Data Elements

- **“Diagnosis, Active: Hemorrhagic Stroke” using "Hemorrhagic Stroke Grouping Value Set (2.16.840.1.113883.3.117.1.7.1.212)”**
  - Captured as a Diagnosis Code, Start Date/Time, End Date/Time
  - Code must be from a list of values (called value set) from multiple coding systems (SNOMED CT, ICD-9, ICD-10) indicating Hemorrhagic Stroke
  - The value set is referred to by a name as well as a unique numeric value - 2.16.840.1.113883.3.117.1.7.1.212

- **“Device, Applied: Graduated compression stockings (GCS)” using "Graduated compression stockings (GCS) SNOMEDCT Value Set (2.16.840.1.113883.3.117.1.7.1.256)”**
  - Captured as a Procedure Code, Start Date/Time, End Date/Time
  - Code must be from a list of values (called value set) from SNOMED CT coding system indicating Graduated compression stockings (GCS)
  - The value set is referred to by a name as well as a unique numeric value - 2.16.840.1.113883.3.117.1.7.1.256
VTE1 - eCQM – Algorithm (Partial)

Initial Patient Population =
  - AND: "Patient Characteristic Birthdate: birth date" >= 18 year(s) starts before start of "Occurrence A of Encounter, Performed: Encounter Inpatient"
  - AND: "Occurrence A of Encounter, Performed: Encounter Inpatient (length of stay <= 120 day(s))"
  - AND: "Occurrence A of Encounter, Performed: Encounter Inpatient" ends during "Measurement Period"
  - AND NOT:
    - OR: "Diagnosis, Active: Obstetrics"
    - OR: "Diagnosis, Active: Obstetrics VTE"
    - OR: "Diagnosis, Active: Venous Thromboembolism"
    - starts during "Occurrence A of Encounter, Performed: Encounter Inpatient"

Denominator =
  - AND: "Initial Patient Population"

Denominator Exclusions =
  - AND:
    - OR: "Occurrence A of Encounter, Performed: Encounter Inpatient (length of stay < 2 day(s))"
    - OR: "Occurrence A of Encounter, Performed: ICU Admission or Transfer (length of stay >= 1 day(s))" <= 1 day(s) starts after start of "Occurrence A of Encounter, Performed: Encounter Inpatient"
    - OR: "Diagnosis, Active: Mental Disorders (ordinality: 'Principal')" starts during "Occurrence A of Encounter, Performed: Encounter Inpatient"
    - OR:
      - OR: "Procedure, Performed: General Surgery (ordinality: 'Principal')"
      - OR: "Procedure, Performed: Gynecological Surgery (ordinality: 'Principal')"
      - OR: "Procedure, Performed: Hip Fracture Surgery (ordinality: 'Principal')"
      - OR: "Procedure, Performed: Hip Replacement Surgery (ordinality: 'Principal')"
      - OR: "Procedure, Performed: Intracranial Neurosurgery (ordinality: 'Principal')"
      - OR: "Procedure, Performed: Knee Replacement Surgery (ordinality: 'Principal')"
      - OR: "Procedure, Performed: Urological Surgery (ordinality: 'Principal')"
      - during "Occurrence A of Encounter, Performed: Encounter Inpatient"
    - OR:
      - OR: "Diagnosis, Active: Hemorrhagic Stroke (ordinality: 'Principal')"
      - OR: "Diagnosis, Active: Ischemic Stroke (ordinality: 'Principal')"
      - starts during "Occurrence A of Encounter, Performed: Encounter Inpatient"
    - OR:
      - AND: "Occurrence A of Encounter, Performed: Encounter Inpatient" <= 1 hour(s) starts after end of "Occurrence A of Encounter, Performed: Encounter Inpatient"
Differences Between CMS and TJC eCQM Reporting Requirements
CMS eCQM Electronic Reporting Option for 2015

- Hospitals that electronically report …
  - 1 quarter of data (1Q 2015, 2Q 2015, 3Q 2015)
  - for minimum of 16 out of the 28 available eCQMs (ED-3 not included)
  - By Nov 30, 2015
  - Using 2014 Edition certified EHR technology

- …would meet
  - quality reporting requirement of MU for FY2015 AND
  - some of the quality reporting requirements of the Hospital IQR program

- IQR program would still require separately submitting chart abstracted measures to CMS for the measures that have not been submitted as eCQM.
# TJC Flexible Reporting Options for 2015

The table below outlines the flexible reporting options for 2015, categorized into three main options:

### Option 1

**Select and Report Data on:** Modified Sets of Chart-Abstracted Measures

- Select and report on six of twelve sets of chart-abstracted measures for calendar year 2015 applicable to the services provided and patient populations served by the hospital.
- Perinatal Care will remain required as one of the six sets if applicable, i.e., at least 1,100 live births per year.

<table>
<thead>
<tr>
<th>Joint Commission Chart Abstraction Measure Sets</th>
</tr>
</thead>
<tbody>
<tr>
<td>AMI-7a</td>
</tr>
<tr>
<td>CAC-3</td>
</tr>
<tr>
<td>ED-1a, ED-2a</td>
</tr>
<tr>
<td>PC-01, PC-02, PC-03, PC-04, PC-05/6a</td>
</tr>
<tr>
<td>STK-1, STK-2, STK-3, STK-4, STK-5, STK-6, STK-8, STK-10</td>
</tr>
<tr>
<td>SCIP-INF-4</td>
</tr>
<tr>
<td>VTE-1, VTE-2, VTE-3, VTE-5, VTE-6</td>
</tr>
<tr>
<td>IMM-2</td>
</tr>
<tr>
<td>HBIPS-1, HBIPS-2, HBIPS-3, HBIPS-4, HBIPS-5, HBIPS-6, HBIPS-7</td>
</tr>
<tr>
<td>SUB-1, SUB-2, SUB-3, SUB-4</td>
</tr>
<tr>
<td>TOB-1, TOB-2, TOB-3, TOB-4</td>
</tr>
<tr>
<td>OP measures used by Joint Commission</td>
</tr>
</tbody>
</table>

### Option 2

**Select and Report Data on:** eCQM Measure Sets Only

- Select and report on six of the seven eCQM sets applicable to the services provided and patient populations served by the hospital. Report on a minimum of one calendar quarter or up to three consecutive calendar quarters for 2015.
- Perinatal Care will remain required as one of the six sets if applicable, i.e., at least 1,100 live births per year.

<table>
<thead>
<tr>
<th>Joint Commission eCQM Measure Sets</th>
</tr>
</thead>
<tbody>
<tr>
<td>AMI-7a</td>
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</tr>
<tr>
<td>ED-1a, ED-2a</td>
</tr>
<tr>
<td>PC-01, PC-02, PC-03, PC-04, PC-05/6a</td>
</tr>
<tr>
<td>STK-2, STK-3, STK-4, STK-5, STK-6, STK-8, STK-10</td>
</tr>
<tr>
<td>SCIP-INF-1a, SCIP-INF-9</td>
</tr>
<tr>
<td>VTE-1, VTE-2, VTE-3, VTE-5, VTE-6</td>
</tr>
</tbody>
</table>

### Option 3

**Select and Report Data on:** Combination of Chart-Abstracted and eCQM Measure Sets

- Select and report on six sets of core measures applicable to the services provided and patient populations served by the hospital.
- Perinatal Care will remain required as one of the six sets if applicable, i.e., at least 1,100 live births per year.
- Measure sets will be selected from among the available complement of core measure sets (see Options 1 and 2).
- Hospitals wishing to select this option and that may be interested in reporting on the same set(s) of chart-abstracted and eCQM Measures should contact Frank Zibrat at 630-792-5992 or via e-mail at fzibrat@jointcommission.org
- See notes under Option 2.
Quality Measure Reporting Workflow—Core Measures (CDQM) vs. eCQM (MUQM)
Core Measures Product (CDQM) Workflow

- Upload final billed administrative data to CareDiscovery Quality Measures (CDQM)
- CDQM processes data thru algorithms and identifies, samples and creates a work list
- Abstractor collects data, CDQM identifies “errors and warnings” for correction prior to submission
- CDQM submits data to CMS and TJC
- CDQM displays results of CMS submission
- Abstractor has opportunity to find and fix data errors - CDQM will resubmit up till CMS submission deadline
eCQM Product – Meaningful Use Quality Manager (MUQM)

- 2014 edition ONC-ACB certified solution for eCQM reporting
- Approved TJC ORYX eMeasure Vendor
- Currently certified to 23 of the 29 eCQMs from MU Stage 2
- Certified 23 measures cover 6 of the 7 measure sets currently available with the TJC eCQM reporting options in 2015 –
  - Emergency Department (ED)
  - Stroke (STK) - STK
  - Venous Thromboembolism (VTE)
  - Acute Myocardial Infarction (AMI)
  - Perinatal Care (PC)
  - Children’s Asthma Care (CAC-3)
eCQM Product (MUQM) Workflow

1) Initially – clients map data from EHR to data elements needed for eCQM calculations

2) Create input file with episode data (file can have data for multiple episodes)

3) Upload file to MUQM

4) Review data quality errors

5) Fix errors by re-uploading episode data file (No manual abstraction in MUQM) – Review data quality errors

6) Review measure results

7) Report to CMS
   - Aggregate measure results - by attestation to meet MU (OR)
   - Truven submits electronic patient level data files using standardized format to CMS

8) Report to TJC
   - Electronic reporting
   - Indicate to TJC measures to report (by Nov 30 of prior year)
   - Inform Truven
   - Truven submits patient data in standardized formats to TJC
Preparing for Transition
Preparing for Transition to eCQMs

- Does your quality department understand the eCQM process?
- How comfortable is your organization with the EHR data used for eCQMs?
- How comfortable is your organization with the eCQM results?
- Is your organization reviewing the data and results and comparing to core measures for accuracy?
- Have you figured out timing of your transition planning?
  - Have you factored in TJC requirements (submission by vendor)
### MU Proposed Rule – CQM Progression Table

<table>
<thead>
<tr>
<th></th>
<th>CY2015</th>
<th>CY2016</th>
<th>CY2017</th>
<th>CY2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reporting Period</td>
<td>Any continuous 90 days between Oct 1, 2014 and Dec 31, 2015</td>
<td>- Full Year - 90 days for first time MU reporting</td>
<td>-Full Year for all providers -Medicaid (90 days)¹</td>
<td>-Full Year for all providers -Medicaid (90 days)¹</td>
</tr>
<tr>
<td>Reporting Method</td>
<td>Attestation OR Electronic Submission</td>
<td>Attestation OR Electronic Submission</td>
<td>Attestation OR Electronic Submission</td>
<td>Electronic Submission only (Exceptions)²</td>
</tr>
<tr>
<td>Elec. Reporting (Req. for Hospital IQR in 2016)</td>
<td>Q1 or Q2 or Q3 (Nov 30, 2015)</td>
<td>Q3 (Nov 30, 2016) AND Q4 (Feb 28, 2017)</td>
<td>Full Year</td>
<td>Full Year</td>
</tr>
<tr>
<td>Specifications</td>
<td>April 2014 Annual Update</td>
<td>April 2015 Annual Update</td>
<td>April 2016 Annual Update</td>
<td>April 2017 Annual Update³</td>
</tr>
</tbody>
</table>

¹For EHs demonstrating MU for the first time under Medicaid – any 90 continuous days
²Data submission system failure, natural disaster or certification issue outside the control of the provider → may use attestation
³Can use April 2016 Annual Update if eligible for attestation (Medicaid and Exceptions in footnote 3)
### IPPS Final Rule
To be Published on Aug 17, 2015

#### For Hospital IQR for FY2018 (in CY2016), CMS will require
- electronic reporting of a minimum of **4 eCQMs** out of 28
- **3rd or 4th** Quarter 2016
- By **Feb 28, 2017**
- No NQS domain distribution is required
- Either 2014 or 2015 Edition Certified EHR
- Six previously adopted measures (ED-1, ED-2, PC-01, STK-04, VTE-5, and VTE-6) must still be submitted via chart-abstraction regardless of whether they are also submitted as electronic clinical quality measures

#### For EHR Incentive Program in 2016
- Attestation OR Electronic Reporting
- **Attestation**
  - 16 eCQMs out of 29
  - Must cover 3 out of 6 domains
  - 4 calendar quarters in 2016
  - Report by Feb 28, 2017
- **Electronic Reporting**
  - 4 eCQMs out of 28
  - **3rd or 4th** quarter 2016
  - Report by Feb 28, 2017
Comparing Core Measure and eCQM Results

- Why compare results?
  - Ensure accuracy of eCQM results
  - Determine what data may need to be captured in EHRs for accurate eCQM calculations
  - Provides confidence in making informed decision to transition to eCQMs and electronic reporting

- Just get started…
  - Review existing processes
  - May be start with comparing one measure result from your EHR and compare it to your core measure results

- We’ll walk you through an example of how Truven is performing this comparison
Comparing Core Measure and eCQM Results – Truven

- Hospitals that use both the Truven CDQM and MUQM solutions can use a dashboard
  - Compare measure results across products
  - Drill down to analyze data and identify causes of discrepancies
  - Analyze and correct any identified issues ensuring accurate results for submissions and improve quality of care
### CDQM/MUQM Comparison - Truven Dashboard Example 1 (STK-2)

<table>
<thead>
<tr>
<th>Eocid</th>
<th>Match Detail</th>
<th>MUQM Categorization</th>
<th>CDQM Categorization</th>
<th>MUQM Reason</th>
<th>CDQM Reason</th>
</tr>
</thead>
<tbody>
<tr>
<td>EOC-1</td>
<td>Categorization Mismatch</td>
<td>In Numerator</td>
<td>Not in measure population</td>
<td>Ischemic stroke - Discharged on anti-thrombotic therapy</td>
<td>Discharge Disposition in (2,3,4,6,7)</td>
</tr>
</tbody>
</table>

**Question** – Why is EOC in MU Population but **not** in Core Measures population?

<table>
<thead>
<tr>
<th>MUQM</th>
<th>CDQM</th>
</tr>
</thead>
<tbody>
<tr>
<td>•MUQM-&gt; Discharge Disposition: NUBC=62 (Rehabilitation)</td>
<td>•CDQM-&gt; Discharge Disposition: 3 (Hospice – Health Care Facility)</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>•Researched this further in the CDQM product (Audit Trail) <strong>(CDQM and MUQM team working together)</strong></td>
</tr>
<tr>
<td></td>
<td>•Initially uploaded as 5 (Other Health Care Facility) in CDQM</td>
</tr>
<tr>
<td></td>
<td>•But then it was modified to 3 through abstraction</td>
</tr>
</tbody>
</table>

- You are trying to identify if there is a pattern amongst the differences in the results.
CDQM/MUQM Comparison - Truven Dashboard Example 2 (VTE-3)

Question – Why is EOC in MU Population but not in Core Measures population?

<table>
<thead>
<tr>
<th>Eocid</th>
<th>Match Detail</th>
<th>MUQM Categorization</th>
<th>CDQM Categorization</th>
<th>MUQM Reason</th>
<th>CDQM Reason</th>
</tr>
</thead>
<tbody>
<tr>
<td>EOC-2</td>
<td>Categorization Mismatch</td>
<td>In Numerator</td>
<td>Not in measure population</td>
<td>VTE Patients with Anticoagulation OverlapTherapy</td>
<td>VTE Confirmed is N</td>
</tr>
</tbody>
</table>

MUQM

VTE Diagnostic Test → VTE Confirmed: 233935004 (Pulmonary Embolism):

Q - How does this code get entered into the Medical Record?

CDQM

VTE Confirmed = N

- If you had this discrepancy, what would you be thinking? Is there a pattern?
<table>
<thead>
<tr>
<th>Eocid</th>
<th>Match Detail</th>
<th>MUQM Categorization</th>
<th>CDQM Categorization</th>
<th>MUQM Reason</th>
<th>CDQM Reason</th>
</tr>
</thead>
<tbody>
<tr>
<td>EOC-3</td>
<td>Categorization Mismatch</td>
<td>Not In Denominator Inclusion</td>
<td>In numerator population</td>
<td>VTE not confirmed through diagnostic testing or warfarin/heparin not administered in a timely manner</td>
<td>Reason for Discontinuation of Parenteral Therapy = Y</td>
</tr>
</tbody>
</table>

Question – Why is EOC not in MU population but is in CDQM population?

<table>
<thead>
<tr>
<th>MUQM</th>
<th>There was <strong>no</strong> VTE Diagnostic Test that confirmed VTE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><img src="image" alt="Diagnostic Study, Result: VTE Diagnostic Test" /></td>
</tr>
<tr>
<td></td>
<td>No matching data</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>CDQM</th>
<th>It shows that VTE Diagnostic Test was performed and VTE was Confirmed</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><img src="image" alt="VTE Confirmed" /> <img src="image" alt="VTE Diagnostic Test" /></td>
</tr>
</tbody>
</table>

- Research the medical record to find out what was the actual result for the VTE Diagnostic Test.
Summary

- CMS is gradually aligning Core Measures and MU eCQMs

- Electronic reporting is currently voluntary, but CMS is making it required starting 2016

- TJC is providing a voluntary electronic reporting option of eCQMs starting in 2015

- Following CMS’s lead, TJC may require electronic submissions in the future
Take Away Points

- Hospitals should have a plan for transitioning to electronic reporting of eCQMs to CMS and TJC as they become required
  - Educate & collaborate (Quality and IT teams need to work together)

- Before electronic reporting of eCQMs becomes required, hospitals should make sure they have a good understanding of
  - eCQMs
  - data needed for accurate eCQM calculations
  - how the eCQM results match or mismatch from their core measure results

- Electronic Reporting to CMS and TJC is new and likely to be complicated
  - Make sure you are comfortable with your EHR vendor’s ability to assist you in successfully transitioning to electronic reporting
Truven Health eCQM Solution – Meaningful Use Quality Manager

- 2014 Edition ONC-ACB certified for 23 eCQMs (out of 29) for Hospitals

- Approved ORYX vendor for TJC eCQM submissions

- Certified 23 measures cover 6 of the 7 measure sets currently available with the TJC eCQM reporting options in 2015 –
  - Emergency Department (ED)
  - Stroke (STK) - STK
  - Venous Thromboembolism (VTE)
  - Acute Myocardial Infarction (AMI)
  - Perinatal Care (PC)
  - Children’s Asthma Care (CAC-3)
Truven Health eCQM Solution – Meaningful Use Quality Manager

- Provides aggregate eCQM results to meet MU attestation requirements
- Provides ability to compare core measure results to eCQM results
  - Allows hospitals to validate the accuracy of their eCQM results before making the transition
- Truven will perform electronic submissions on behalf of our clients to both CMS and TJC
- Additional functionality available to assess hospitals performance over time (trends), create custom benchmarks and compare performance against the benchmarks, health care system reporting etc.
For more information

- Call 1-800-525-9083 option 4 to speak with a product specialist and ask about our Meaningful Use Quality Manager Solution

- Visit truvenhealth.com/your-healthcare-focus/hospital-management-decisions/meaningful-use-quality-manager