

BMI eMeasure Feasibility Scorecard

***NQF Measure #2828
Preventive Care and Screening:
Body Mass Index (BMI) Screening and Follow-Up Plan***

***A special project for the Centers for Medicare & Medicaid Services (CMS)
and the National Quality Forum (NQF)***

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eMeasure Feasibility Scorecard Practice A

Measure Title: Preventive Care and Screening:
Body Mass Index (BMI) Screening and Follow-up Plan

Who Performed the Assessment?: QIP

Date of Testing: 12/4/2015

EHR System Used: Care 360

Data Element(s):

- Age (number)
- Sex (character, text)
- Race (character, text)
- Ethnicity (character, text)
- Payer (character, text)
- Date of encounter (date, dd-mm-yyyy)
- Type of encounter (CPT, SMOMED-CT, HCPCS)
- Palliative care (CPT, SMOMED-CT, HCPCS)
- Patient refusal of BMI measurement (CPT, SMOMED-CT, HCPCS)
- Patient in urgent or emergent medical situation (CPT, SMOMED-CT, HCPCS)
- BMI assessment (CPT, SNOMED-CT, HCPCS)
- Date of BMI assessment (≤ 6 months before or during date of encounter) (date, dd-mm-yyyy)
- BMI result (LOINC)
- Type of follow-up performed for abnormal BMI (CPT, SNOMED-CT, HCPCS)
- Date of follow-up performed for abnormal BMI (≤ 6 months before or during date of encounter) (date, dd-mm-yyyy)
- Exclusions – pregnancy (CPT, SNOMED-CT, HCPCS)

Data Element(s) Definition(s): see measure specifications

Data Element Object Identifier(s) (OID): see Coding Evolution table

Are Any Data Elements Generated by an Interoperable System?: (Y/N) N **System(s)**

Identify Data Elements Generated by Interoperable System(s):

Type of Setting or Practice:

- ✓ **Solo Practice**
- ☐ Large Group Practice
- ☐ Single Hospital
- ☐ Academic Hospital
- ☐ Hospital Network
- ☐ Critical Access Hospital
- ☐ Community Health Center
- ☐ Safety-Net Clinic
- ☐ Integrated Delivery Network
- ☐ Other (please describe):

Component	Current	Future – Within One Year	Explanation
<p>Data Availability – Are the data readily available in a structured format?</p> <p>Scale:</p> <p>3 – Data elements exist in structured format in EHRs that were tested</p> <p>2- Not defined at this time. Hold for possible future use</p> <p>1 – Data elements are not available in a structured format within the EHRs tested for this measure</p>	Average current score for all data elements 2.4	Average future score for all data elements 2.4	<p>The practice indicated that they do not capture “type of follow-up performed” or “date of follow-up.” All patients receive BMI screening, and patients outside normal range receive patient education, which is documented in care plans as free text. The provider is not documenting follow-up in a way that the EHR is capturing for inclusion in the numerator, and consequently performance score likely underestimates true performance.</p> <p>Practice did not see palliative care patients and indicated that the concept is not captured in structured format.</p> <p>The concept of “urgent or emergent care” is not captured but may be held for future use.</p> <p>Practice says they do not capture pregnancy because they don’t see pregnant patients.</p>
<p>Data Accuracy – Does the information contained in the data element fully represent the intent of the measure logic for that data element? Are the data source and recorder specified?</p> <p>3 – The information is from the most authoritative source and/or is highly likely to be correct (e.g., laboratory test results transmitted directly from the laboratory system into the EHR)</p> <p>2 – The information may not be from the most authoritative source and/or has a moderate likelihood of being correct (e.g., self-report of a vaccination)</p> <p>1 – The information may not be correct (e.g., a check box that indicates medication/reconciliation was performed)</p>	Average current score for all data elements 2.4	Average future score for all data elements 2.5	See above.

Component	Current	Future – Within One Year	Explanation
<p>Data Standards – Are the data elements coded using a nationally accepted terminology standard?</p> <p>Scale:</p> <p>3 – The data elements are coded in a nationally accepted terminology standard</p> <p>2 – Terminology standards for these data elements are currently available, but it is not consistently coded to standard terminology in the EHR, or the EHR does not easily allow such coding</p> <p>1 – The EHR does not support coding to the existing standard</p>	Average current score for all data elements 2.7	Average current score for all data elements 2.8	See above.
<p>Workflow – To what degree are the data elements captured during the course of care? How does it impact the typical workflow for that user?</p> <p>Scale:</p> <p>3 – The data elements are routinely collected as part of routine care and require no additional data entry from a clinician or other provider solely for the quality measure and no EHR user interface changes. Examples would be lab values, vital signs, referral orders, or problem list entry.</p> <p>2 – Data elements are not routinely collected as a part of routine care, and additional time and effort over and above routine care is required, but perceived to have some benefit.</p> <p>1 – Additional time and effort over and above routine care is required to collect data elements without immediate benefit to care.</p>	Average current score for all data elements 2.4	Average future score for all data elements 2.4	See above.

eMeasure Feasibility Scorecard Practice B

Measure Title: Preventive Care and Screening:
Body Mass Index (BMI) Screening and Follow-up Plan

Who Performed the Assessment?: QIP

Date of Testing: 11/19/2015

EHR System Used: Health Fusion

Data Element(s):

- Age (number)
- Sex (character, text)
- Race (character, text)
- Ethnicity (character, text)
- Payer (character, text)
- Date of encounter (date, dd-mm-yyyy)
- Type of encounter (CPT, SMOMED-CT, HCPCS)
- Palliative care (CPT, SMOMED-CT, HCPCS)
- Patient refusal of BMI measurement (CPT, SMOMED-CT, HCPCS)
- Patient in urgent or emergent medical situation (CPT, SMOMED-CT, HCPCS)
- BMI assessment (CPT, SNOMED-CT, HCPCS)
- Date of BMI assessment (≤ 6 months before or during date of encounter) (date, dd-mm-yyyy)
- BMI result (LOINC)
- Type of follow-up performed for abnormal BMI (CPT, SNOMED-CT, HCPCS)
- Date of follow-up performed for abnormal BMI (≤ 6 months before or during date of encounter) (date, dd-mm-yyyy)
- Exclusions – pregnancy (CPT, SNOMED-CT, HCPCS)

Data Element(s) Definition(s): see measure specifications

Data Element Object Identifier(s) (OID): see Coding Evolution table

Are Any Data Elements Generated by an Interoperable System: (Y/N) N **System(s)**

Identify Data Elements Generated by Interoperable System(s):

Type of Setting or Practice:

- ☐ Solo Practice
- ☐ Large Group Practice
- ☐ Single Hospital
- ☐ Academic Hospital
- ☐ Hospital Network
- ☐ Critical Access Hospital
- ☐ Community Health Center
- ☐ Safety-Net Clinic
- ☐ Integrated Delivery Network
- ☒ **Other (please describe): 2 physician practice**

Component	Current	Future – Within One Year	Explanation
<p>Data Availability – Are the data readily available in a structured format?</p> <p>Scale:</p> <p>3 – Data elements exist in structured format in EHRs that were tested</p> <p>2- Not defined at this time. Hold for possible future use</p> <p>1 – Data elements are not available in a structured format within the EHRs tested for this measure</p>	Average current score for all data elements 2.8	Average future score for all data elements 2.9.	Practice indicates the inability to capture “patient refusal” and “urgent or emergent care” in structured format but acknowledges the future potential for adding these concepts in discrete data fields. All other data elements are available. Clinicians select follow-up options via a drop-down menu in the EHR.
<p>Data Accuracy – Does the information contained in the data element fully represent the intent of the measure logic for that data element? Are the data source and recorder specified?</p> <p>3 – The information is from the most authoritative source and/or is highly likely to be correct (e.g., laboratory test results transmitted directly from the laboratory system into the EHR)</p> <p>2 – The information may not be from the most authoritative source and/or has a moderate likelihood of being correct (e.g, self-report of a vaccination)</p> <p>1 – The information may not be correct (e.g., a check box that indicates medication/reconciliation was performed)</p>	Average current score for all data elements 2.9	Average future score for all data elements 2.9	See above.
<p>Data Standards – Are the data elements coded using a nationally accepted terminology standard?</p> <p>Scale:</p> <p>3 – The data elements are coded in a nationally accepted terminology standard</p> <p>2 – Terminology standards for these data elements are currently available, but it is not consistently coded to standard terminology in the EHR, or the EHR does not easily allow such coding</p> <p>1 – The EHR does not support coding to the existing standard</p>	Average current score for all data elements 2.8	Average current score for all data elements 2.9	See above.

Component	Current	Future – Within One Year	Explanation
<p>Workflow – To what degree are the data elements captured during the course of care? How does it impact the typical workflow for that user?</p> <p>Scale:</p> <p>3 – The data elements are routinely collected as part of routine care and require no additional data entry from a clinician or other provider solely for the quality measure and no EHR user interface changes. Examples would be lab values, vital signs, referral orders, or problem list entry.</p> <p>2 – Data elements are not routinely collected as a part of routine care, and additional time and effort over and above routine care is required, but perceived to have some benefit.</p> <p>1 – Additional time and effort over and above routine care is required to collect data elements without immediate benefit to care.</p>	<p>Average current score for all data elements 3.0</p>	<p>Average future score for all data elements 3.0</p>	<p>None.</p>

eMeasure Feasibility Scorecard Practice C

Measure Title: Preventive Care and Screening:
Body Mass Index (BMI) Screening and Follow-up Plan

Who Performed the Assessment?: QIP

Date of Testing: 2/12/2016

EHR System Used: Allscripts

Data Element(s):

- Age (number)
- Sex (character, text)
- Race (character, text)
- Ethnicity (character, text)
- Payer (character, text)
- Date of encounter (date, dd-mm-yyyy)
- Type of encounter (CPT, SMOMED-CT, HCPCS)
- Palliative care (CPT, SMOMED-CT, HCPCS)
- Patient refusal of BMI measurement (CPT, SMOMED-CT, HCPCS)
- Patient in urgent or emergent medical situation (CPT, SMOMED-CT, HCPCS)
- BMI assessment (CPT, SNOMED-CT, HCPCS)
- Date of BMI assessment (\leq 6 months before or during date of encounter) (date, dd-mm-yyyy)
- BMI result (LOINC)
- Type of follow-up performed for abnormal BMI (CPT, SNOMED-CT, HCPCS)
- Date of follow-up performed for abnormal BMI (\leq 6 months before or during date of encounter) (date, dd-mm-yyyy)
- Exclusions – pregnancy (CPT, SNOMED-CT, HCPCS)

Data Element(s) Definition(s): see measure specifications

Data Element Object Identifier(s) (OID): see Coding Evolution table

Are Any Data Elements Generated by an Interoperable System: (Y/N) N **System(s)**

Identify Data Elements Generated by Interoperable System(s):

Type of Setting or Practice:

- ☐ Solo Practice
- ☒ **Large Group Practice**
- ☐ Single Hospital
- ☐ Academic Hospital
- ☐ Hospital Network
- ☐ Critical Access Hospital
- ☐ Community Health Center
- ☐ Safety-Net Clinic
- ☐ Integrated Delivery Network
- ☐ Other (please describe):

Component	Current	Future – Within One Year	Explanation
<p>Data Availability – Are the data readily available in a structured format?</p> <p>Scale:</p> <p>3 – Data elements exist in structured format in EHRs that were tested</p> <p>2- Not defined at this time. Hold for possible future use</p> <p>1 – Data elements are not available in a structured format within the EHRs tested for this measure</p>	Average current score for all data elements 2.9	Average future score for all data elements 3.0	Practice indicated a near-term path for capturing “urgent or emergent care” and “type of follow-up performed.” Follow-up plans are documented in progress notes, and practice described this documentation as inconsistent. Practice plans to implement EPIC, which may mitigate this challenge.
<p>Data Accuracy – Does the information contained in the data element fully represent the intent of the measure logic for that data element? Are the data source and recorder specified?</p> <p>3 – The information is from the most authoritative source and/or is highly likely to be correct (e.g., laboratory test results transmitted directly from the laboratory system into the EHR)</p> <p>2 – The information may not be from the most authoritative source and/or has a moderate likelihood of being correct (e.g, self-report of a vaccination)</p> <p>1 – The information may not be correct (e.g., a check box that indicates medication/reconciliation was performed)</p>	Average current score for all data elements 3.0	Average future score for all data elements 3.0	None.
<p>Data Standards – Are the data elements coded using a nationally accepted terminology standard?</p> <p>Scale:</p> <p>3 – The data elements are coded in a nationally accepted terminology standard</p> <p>2 – Terminology standards for these data elements are currently available, but it is not consistently coded to standard terminology in the EHR, or the EHR does not easily allow such coding</p> <p>1 – The EHR does not support coding to the existing standard</p>	Average current score for all data elements 2.88	Average current score for all data elements 3.0	See above.

Component	Current	Future – Within One Year	Explanation
<p>Workflow – To what degree are the data elements captured during the course of care? How does it impact the typical workflow for that user?</p> <p>Scale:</p> <p>3 – The data elements are routinely collected as part of routine care and require no additional data entry from a clinician or other provider solely for the quality measure and no EHR user interface changes. Examples would be lab values, vital signs, referral orders, or problem list entry.</p> <p>2 – Data elements are not routinely collected as a part of routine care, and additional time and effort over and above routine care is required, but perceived to have some benefit.</p> <p>1 – Additional time and effort over and above routine care is required to collect data elements without immediate benefit to care.</p>	<p>Average current score for all data elements 2.75</p>	<p>Average future score for all data elements 3.0</p>	<p>None.</p>