CME Disclosures

J.N. Cook, D.O. MPH has nothing to disclose

Randi Terry, MBA has nothing to disclose
Credit where credit is due
What is Meaningful Use?

- American Recovery and Reinvestment Act, Signed into law in February 2009, final Stage One regulations in July 2010, Stage Two in September 2012
- Also called HITECH or stimulus bill
- Medicare and Medicaid “EHR incentive Program”.

[Recovery.gov logo: RECOVERY.gov TRACK THE MONEY]
Intent of HITECH Program

1. Improve quality, safety, efficiency, and reduce health disparities
2. Engage patients and families
3. Improve care coordination
4. Ensure adequate privacy and security protections for personal health information
5. Improve population and public health

Oh yeah, reduce the cost of our healthcare system.

Policymaking, Rules, & Regulation
How to Qualify

1. Use a certified EHR
   - [Certified HIT Product List (CHPL)]

2. Register with CMS
   - [EHR Incentive Programs]

3. Meet ‘Meaningful Use’ Criteria
   - Staged criteria based on year of participation

4. Report to CMS
Free Money… Really?

• Complicated
• May require additional staff
• Will slow down providers at first
• Lots of roadblocks
• It’s a journey, once started you cannot stop

IT’S GOOD FOR OUR PATIENTS
Potential Roadblocks

- Certified EHR means acquire (not necessarily implement) all modules required for MU, even those to which you are NOT attesting (Stage 1)
- Is your EHR certified?
- Do you have all required modules to meet all requirements
- MU criteria reporting generally requires significant process redesign and training in addition to application enhancements
- Added responsibility and process change for everyone
Potential Roadblocks

• Requires coordination with the state/regional HIE, physicians practices, and others
• Implementation requires significant effort to:
  • Define clinical and administrative workflows
  • Develop data sharing agreements and business associate agreements (BAA)
For Medicare, that depends on how much and how soon you want to begin receiving incentives.

### Medicare Payment Incentives

<table>
<thead>
<tr>
<th>First Year</th>
<th>Minimum Charges</th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
<th>2014</th>
<th>2015 +</th>
</tr>
</thead>
<tbody>
<tr>
<td>2011</td>
<td>$24,000</td>
<td>$18,000</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2012</td>
<td>$24,000</td>
<td>$12,000</td>
<td>$18,000</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>2013</td>
<td>$16,000</td>
<td>$8,000</td>
<td>$12,000</td>
<td>$15,000</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>2014</td>
<td>$11,000</td>
<td>$4,000</td>
<td>$8,000</td>
<td>$12,000</td>
<td>$12,000</td>
<td>$0</td>
</tr>
<tr>
<td>2015</td>
<td>$5,400</td>
<td>$2,000</td>
<td>$4,000</td>
<td>$8,000</td>
<td>$8,000</td>
<td>$0</td>
</tr>
<tr>
<td>2016</td>
<td>$2,700</td>
<td>$2,000</td>
<td>$4,000</td>
<td>$4,000</td>
<td>$4,000</td>
<td>$0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$44,000</strong></td>
<td><strong>$44,000</strong></td>
<td><strong>$39,000</strong></td>
<td><strong>$24,000</strong></td>
<td><strong>$0</strong></td>
<td></td>
</tr>
</tbody>
</table>

Incentives are based on 75% of Medicare-Allowed Charges for the participating year. There is a 10% Bonus availability per year if HSPA.

A 1% reduction is applied if MU is not achieved by 2015, then and additional 1% in 2016 - 2017. This may continue to 95% if less than 75% of EPs have adopted.

Payments are made 4 to 8 weeks after attestation that demonstrates MU. However, EPs must also have met the threshold for allowed charges for covered professional services at that time or payment will be delayed.
For Medicaid, an EP can begin as late as 2016 and still receive the maximum incentives.

### Medicaid Payment Incentives

<table>
<thead>
<tr>
<th>First Year</th>
<th>2012</th>
<th>2013</th>
<th>2014</th>
<th>2015</th>
<th>2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>2012</td>
<td>$21,250</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>2013</td>
<td>$8,500</td>
<td>$21,250</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>2014</td>
<td>$8,500</td>
<td>$8,500</td>
<td>$21,250</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>2015</td>
<td>$8,500</td>
<td>$8,500</td>
<td>$8,500</td>
<td>$21,250</td>
<td>$0</td>
</tr>
<tr>
<td>2016</td>
<td>$8,500</td>
<td>$8,500</td>
<td>$8,500</td>
<td>$8,500</td>
<td>$21,250</td>
</tr>
<tr>
<td>2017</td>
<td>$8,500</td>
<td>$8,500</td>
<td>$8,500</td>
<td>$8,500</td>
<td>$8,500</td>
</tr>
<tr>
<td>2018</td>
<td>$0</td>
<td>$8,500</td>
<td>$8,500</td>
<td>$8,500</td>
<td>$8,500</td>
</tr>
<tr>
<td>2019</td>
<td>$0</td>
<td>$0</td>
<td>$8,500</td>
<td>$8,500</td>
<td>$8,500</td>
</tr>
<tr>
<td>2020</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$8,500</td>
<td>$8,500</td>
</tr>
<tr>
<td>2021</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$8,500</td>
</tr>
<tr>
<td>Total</td>
<td>$63,750</td>
<td>$63,750</td>
<td>$63,750</td>
<td>$63,750</td>
<td>$63,750</td>
</tr>
</tbody>
</table>

Incentives are based on EP meeting a minimum 30% Medicaid Patient Volume. Pediatricians ONLY can have a minimum of 20% Medicaid patient volume, but if they have only 20%, then they are eligible for $42,500.

NC Program URL: [http://www.ncdhhs.gov/healthit/](http://www.ncdhhs.gov/healthit/)
Timing – AIU Medicaid Example

**AIU Start in 2011**

- **Medicaid AIU**
- **Stage 1, Year 1**: Any 90 days
- **Stage 1, Year 2**: 365 Days Attestation
- **Stage 2, Year 1**: Any Quarter
- **Stage 2, Year 2**: 365 Days Attestation

**AIU, Start in 2012**

- **Medicaid AIU**
- **Stage 1, Year 1**: Any 90 days
- **Stage 1, Year 2**: Any Quarter
- **Stage 2, Year 1**: 365 Days Attestation

**AIU, Start in 2013**

- **Stage 1, Year 1**
- **Stage 1, Year 2**: Any Quarter
- **Stage 1, Year 2**: 365 Days Attestation
Timing – Medicare Example

<table>
<thead>
<tr>
<th>Year</th>
<th>Start</th>
<th>Stage 1 Year 1</th>
<th>Stage 1 Year 2</th>
<th>Stage 1 Year 3</th>
<th>Stage 2 Year 1</th>
<th>Stage 2 Year 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>2011</td>
<td>Jan</td>
<td>Any 90 days</td>
<td>365 Days Attestation</td>
<td>365 Days Attestation</td>
<td>Any Quarter</td>
<td>365 Days Attestation</td>
</tr>
<tr>
<td>2012</td>
<td>Jan</td>
<td>Any 90 days</td>
<td>365 Days Attestation</td>
<td>365 Days Attestation</td>
<td>Any Quarter</td>
<td>365 Days Attestation</td>
</tr>
<tr>
<td>2013</td>
<td>Jan</td>
<td>Any 90 days</td>
<td>365 Days Attestation</td>
<td>365 Days Attestation</td>
<td>Any Quarter</td>
<td>365 Days Attestation</td>
</tr>
</tbody>
</table>

MUNSON HEALTHCARE
Federal Government is Disappointed

- 16% of providers have received incentives
- 180,200 physicians and hospitals through end of 2012
- $6.1 Billion in Medicare, $4.3 Billion in Medicaid
- 2,000 are attesting daily (in February)
Federal Government is Disappointed
Penalties

For an EP who demonstrates meaningful use in **2013** for the first time:

<table>
<thead>
<tr>
<th>Payment Adjustment Year</th>
<th>2015</th>
<th>2016</th>
<th>2017</th>
<th>2018</th>
<th>2019</th>
<th>2020</th>
</tr>
</thead>
<tbody>
<tr>
<td>Based on 90 day EHR Reporting Period</td>
<td>2013</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Based on Full Year EHR Reporting Period</td>
<td></td>
<td></td>
<td></td>
<td>2014*</td>
<td>2015</td>
<td>2016</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>2017</td>
<td>2018</td>
<td></td>
</tr>
</tbody>
</table>

* Special 3 month EHR reporting period

**To Avoid Payment Adjustments:**
EPs **must** continue to demonstrate meaningful use every year to avoid payment adjustments in subsequent years.
How Much Will I Lose?

- % Adjustment shown below assumes less than 75% of EPs are meaningful users for CY 2018 and subsequent years

<table>
<thead>
<tr>
<th>Payment Adjustment Year</th>
<th>2015</th>
<th>2016</th>
<th>2017</th>
<th>2018</th>
<th>2019</th>
<th>2020</th>
</tr>
</thead>
<tbody>
<tr>
<td>EP is not subject to the payment adjustment for e-Rx in 2014</td>
<td>99%</td>
<td>98%</td>
<td>97%</td>
<td>96%</td>
<td>95%</td>
<td>95%</td>
</tr>
<tr>
<td>EP is subject to the payment adjustment for e-Rx in 2014</td>
<td>98%</td>
<td>98%</td>
<td>97%</td>
<td>96%</td>
<td>95%</td>
<td>95%</td>
</tr>
</tbody>
</table>

- % Adjustment shown below assumes more than 75% of EPs are meaningful users for CY 2018 and subsequent years

<table>
<thead>
<tr>
<th>Payment Adjustment Year</th>
<th>2015</th>
<th>2016</th>
<th>2017</th>
<th>2018</th>
<th>2019</th>
<th>2020</th>
</tr>
</thead>
<tbody>
<tr>
<td>EP is not subject to the payment adjustment for e-Rx in 2014</td>
<td>99%</td>
<td>98%</td>
<td>97%</td>
<td>97%</td>
<td>97%</td>
<td>97%</td>
</tr>
<tr>
<td>EP is subject to the payment adjustment for e-Rx in 2014</td>
<td>98%</td>
<td>98%</td>
<td>97%</td>
<td>97%</td>
<td>97%</td>
<td>97%</td>
</tr>
</tbody>
</table>
Hardships vs. “Just Hard”

Exemptions Not for Everyone

Potential Scenarios

**Qualify for Exemption**
- Insufficient Internet connection
- Opening of a new hospital
- Unforeseen circumstances/ Natural disasters

**Do Not Qualify for Exemption**
- Software upgrade to 2014 Edition
- Changing EHR vendors
- Merger or acquisition

**Notes**
- Hardship exemptions are considered on a case-by-case basis.
- Eligible hospitals must apply for the hardship exemption by April 1 of the year prior to the payment adjustment year (i.e., April 1, 2014 to avoid payment adjustments in FY 2015).

Stage 2 of Meaningful Use

- Published in Federal Register September 4
- Two rules that address both provider requirements and certification by vendors
- Stage 2 will begin on October 1, 2013 for hospitals and January 1, 2014 for physicians.
Stage of Meaningful Use

- Stage 1: Data capturing and sharing
- Stage 2: Advanced clinical processes
- Stage 3: Improved outcomes

CMS

MUNSON HEALTHCARE
Second of Three Increasingly Complex Stages

**Data Capture and Sharing**
*Stage 1*
- Increase implementation and adoption of electronic health record (EHR) systems
- Capture structured data

**Advanced Clinical Processes**
*Stage 2*
- Increase exchange of health information
- Demonstrate care coordination across sites of care
- Empower patients with health information

**Improved Outcomes**
*Stage 3*
- Drive use of real-time data at the point of care
- Use outcomes-focused clinical quality measures
- Utilize clinical decision support for prevention, disease management, and safety
- Provide access to patient self-management tools

CMS Opens More Room for Medicaid Eligibility

Relaxed Medicaid Definitions Lead to Potentially Higher Participation

New Medicaid Eligibility Standards

Patient Volume
EPs and EHs
- Any representative 90-day period in the 12 months preceding the attestation – not the calendar or fiscal year

Patient Population
EPs
- Use a continuous 90-day period in the preceding calendar year; or
- Identify a continuous 90-day period within the 12-month period preceding the EP’s attestation when at least one Medicaid encounter took place with the Medicaid patient in the 24 months prior to the start of the 90-day reporting period

Encounters
EPs and EHs
- Any service rendered on any one day to an individual "enrolled" in a Medicaid program, even if Medicaid did not pay for the service; and
- Encounters for patients who are Title XIX eligible and who meet the definition of "optional targeted low income children"

Notes
- These changes take effect in 2013 and are not applicable to attestations for the 2011 and 2012 program years.
- These changes are optional for states to implement.

Increased % requirements for nearly all measures.

New requirements

Focus on electronic data exchange

Patient portal required

2014 certification process for EHR vendors.
Change from Stage 1 to Stage 2

AND:
- CQM reporting
- Drug-drug alerts
- Drug-allergy alerts
- Drug-formulary alerts
EPs must meet all 17 core objectives:

<table>
<thead>
<tr>
<th>Core Objective</th>
<th>Measure</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. CPOE</td>
<td>Use CPOE for more than 60% of medication, 30% of laboratory, and 30% of radiology</td>
</tr>
<tr>
<td>2. E-Rx</td>
<td>E-Rx for more than 50%</td>
</tr>
<tr>
<td>3. Demographics</td>
<td>Record demographics for more than 80%</td>
</tr>
<tr>
<td>4. Vital Signs</td>
<td>Record vital signs for more than 80%</td>
</tr>
<tr>
<td>5. Smoking Status</td>
<td>Record smoking status for more than 80%</td>
</tr>
<tr>
<td>6. Interventions</td>
<td>Implement 5 clinical decision support interventions + drug/drug and drug/allergy</td>
</tr>
<tr>
<td>7. Labs</td>
<td>Incorporate lab results for more than 55%</td>
</tr>
<tr>
<td>8. Patient List</td>
<td>Generate patient list by specific condition</td>
</tr>
<tr>
<td>9. Preventive Reminders</td>
<td>Use EHR to identify and provide reminders for preventive/follow-up care for more than 10% of patients with two or more office visits in the last 2 years</td>
</tr>
</tbody>
</table>
### Summary - Core

<table>
<thead>
<tr>
<th>Core Objective</th>
<th>Measure</th>
</tr>
</thead>
<tbody>
<tr>
<td>10. Patient Access</td>
<td>Provide online access to health information for more than 50% with more than 5% actually accessing</td>
</tr>
<tr>
<td>11. Visit Summaries</td>
<td>Provide office visit summaries for more than 50% of office visits</td>
</tr>
<tr>
<td>12. Education Resources</td>
<td>Use EHR to identify and provide education resources more than 10%</td>
</tr>
<tr>
<td>13. Secure Messages</td>
<td>More than 5% of patients send secure messages to their EP</td>
</tr>
<tr>
<td>14. Rx Reconciliation</td>
<td>Medication reconciliation at more than 50% of transitions of care</td>
</tr>
<tr>
<td>15. Summary of Care</td>
<td>Provide summary of care document for more than 50% of transitions of care and referrals with 10% sent electronically and at least one sent to a recipient with a different EHR vendor or successfully testing with CMS test EHR</td>
</tr>
<tr>
<td>16. Immunizations</td>
<td>Successful ongoing transmission of immunization data</td>
</tr>
<tr>
<td>17. Security Analysis</td>
<td>Conduct or review security analysis and incorporate in risk management process</td>
</tr>
</tbody>
</table>
Changes to Stage 1: CPOE

Current Stage 1 Measure

Denominator:
Unique patient with at least one medication in their medication list

New Stage 1 Option

Denominator:
Number of orders during the EHR Reporting Period

This optional CPOE denominator is available in 2013 and beyond for Stage 1.
### CPOE

<table>
<thead>
<tr>
<th>Stage 1 Objective</th>
<th>Stage 1 Measure</th>
<th>Stage 2 Objective</th>
<th>Stage 2 Measure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Use CPOE for medication orders directly entered by any licensed healthcare professional who can enter orders into the medical record per state, local and professional guidelines</td>
<td>More than 30% of unique patients with at least one medication in their medication list seen by the EP have at least one medication order entered using CPOE</td>
<td>Use computerized provider order entry (CPOE) for medication, laboratory and radiology orders directly entered by any licensed healthcare professional who can enter orders into the medical record per state, local and professional guidelines</td>
<td>More than 60% of medication, 30% of laboratory, and 30% of radiology orders created by the EP during the EHR reporting period are recorded using CPOE</td>
</tr>
</tbody>
</table>

- **Exclusions:** < 100
- **Different denominator**
- **New definition of licensed healthcare professional**

---

![Munson Healthcare](munson-healthcare.png)
Any licensed healthcare professionals and credentialed medical assistants, can enter orders into the medical record for purposes of including the order in the numerator for the objective of CPOE if they can originate the order per state, local and professional guidelines. Credentialing for a medical assistant must come from an organization other than the organization employing the medical assistant.
<table>
<thead>
<tr>
<th>Stage 1 Objective</th>
<th>Stage 1 Measure</th>
<th>Stage 2 Objective</th>
<th>Stage 2 Measure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Generate and transmit permissible prescriptions</td>
<td>More than 40% of all permissible prescriptions written by the EP are transmitted</td>
<td>Generate and transmit permissible prescriptions</td>
<td>More than 50% of all permissible prescriptions written by the EP are compared to</td>
</tr>
<tr>
<td>electronically (eRx)</td>
<td>electronically using certified EHR technology</td>
<td>electronically (eRx)</td>
<td>at least one drug formulary and transmitted electronically using Certified EHR</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Technology</td>
</tr>
</tbody>
</table>

- Exclusions: < 100, no pharmacy
- FAQ watch: controlled substances
## Interventions - Clinical Decision Support

<table>
<thead>
<tr>
<th>Stage 1 Objective</th>
<th>Stage 1 Measure</th>
<th>Stage 2 Objective</th>
<th>Stage 2 Measure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Implement one clinical decision support rule relevant to specialty or high clinical priority along with the ability to track compliance that rule</td>
<td>Implement one clinical decision support rule</td>
<td>Use clinical decision support to improve performance on high-priority health conditions</td>
<td>1. Implement 5 clinical decision support interventions related to 4 or more clinical quality measures, if applicable, at a relevant point in patient care for the entire EHR reporting period. 2. The EP, eligible hospital, or CAH has enabled the functionality for drug-drug and drug-allergy interaction checks for the entire EHR reporting period</td>
</tr>
</tbody>
</table>

- CDS definition/EHR certification
- CDS-CQM linkage
### Lab Results

<table>
<thead>
<tr>
<th>Stage 1 Objective</th>
<th>Stage 1 Measure</th>
<th>Stage 2 Objective</th>
<th>Stage 2 Measure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Incorporate clinical lab-test results into certified EHR technology as structured data</td>
<td>More than 40% of all clinical lab tests results ordered by the EP during the EHR reporting period whose results are either in a positive/negative or numerical format are incorporated in certified EHR technology as structured data</td>
<td>Incorporate clinical lab-test results into Certified EHR Technology as structured data</td>
<td>More than 55% of all clinical lab tests results ordered by the EP during the EHR reporting period whose results are either in a positive/negative or numerical format are incorporated in Certified EHR Technology as structured data</td>
</tr>
</tbody>
</table>

- Now core
- If your labs are not interfaced, get on the list with Munson or Mercy
Preventive Care/Patient Reminders

<table>
<thead>
<tr>
<th>Preventive Care</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Objective</strong></td>
</tr>
<tr>
<td><strong>Measure</strong></td>
</tr>
</tbody>
</table>

- Now core
- Certification: Use of EHR to select patients for reminders.
A Single Objective, Many Concepts

Growing List of Data Turns into Information and Knowledge

View, Download, and Transmit¹

1. Admit and discharge date and location
2. Reason for hospitalization
3. Current and past problem list
4. Current medication list and medication history
5. Current medication allergy list and medication allergy history
6. Discharge instructions for patient
7. Vital signs at discharge
8. Laboratory test results (available at time of discharge)
9. Summary of care record for transitions of care or referrals to another provider
10. Care plan field(s), including goals and instructions
11. Care team including the attending of record as well as other providers of care
12. Demographics maintained by hospital (sex, race, ethnicity, date of birth, preferred language)
13. Patient name
14. Procedures performed during admission
15. Smoking status

Consolidated and revised Stage 1 measures

The care plan includes “at a minimum the following components: problem (the focus of the care plan), goal (the target outcome) and any instructions that the provider has given to the patient. A goal is a defined target or measure to be achieved in the process of patient care (an expected outcome).”

Another new Stage 2 concept, the summary of care record in both the EP and EH setting requires a list of care team providers.

Data additions to this measures that were mentioned in the NPRM


¹ The view, download, and transmit requirement will replace the e-copy of health information requirement moving forward.
² Notice of proposed rulemaking
Welcome to Baseline Health Connections!

Use Baseline Health Connections to streamline communications with your provider. Select the quick links below or use the left navigation to access additional actions.

- View Messages
- View Results
- View Appointments
- Schedule an Appointment
- Request a Medication Refills
## Use Secure Electronic Messaging

<table>
<thead>
<tr>
<th><strong>Objective</strong></th>
<th>Use secure electronic messaging to communicate with patients on relevant health information.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Measure</strong></td>
<td>A secure message was sent using the electronic messaging function of CEHRT by more than 5 percent of unique patients (or their authorized representatives) seen by the EP during the EHR reporting period.</td>
</tr>
<tr>
<td><strong>Exclusion</strong></td>
<td>Any EP who has no office visits during the EHR reporting period, or any EP who conducts 50 percent or more of his or her patient encounters in a county that does not have 50 percent or more of its housing units with 3Mbps broadband availability according to the latest information available from the FCC on the first day of the EHR reporting period.</td>
</tr>
</tbody>
</table>
Secure Messaging - WHY

• Providers have seen reduction in time responding to inquires and less time spend on the phone
• Secure messaging has also been shown to increase patient satisfaction with their care.
• Research demonstrates that secure messaging has been shown to improve patient adherence to treatment plans.

• While we recognize that EPs cannot directly control whether patients use electronic messaging, we continue to believe that EPs are in a unique position to strongly influence the technologies patients use to improve their own care, including secure electronic messaging.
• We believe that EPs’ ability to influence patients coupled with the low threshold make this measure achievable for all EPs
Summary of Care

Closer Look at Stage 2: Electronic Exchange

Stage 2 focuses on actual use cases of electronic information exchange:

- Stage 2 requires that a provider send a summary of care record for more than 50% of transitions of care and referrals.
- The rule also requires that a provider electronically transmit a summary of care for more than 10% of transitions of care and referrals.
- At least one summary of care document sent electronically to recipient with different EHR vendor or to CMS test EHR.
Visit Summary: Certification Requirement

- Patient name.
- Provider's name and office contact information.
- Date and location of the visit.
- Reason for the office visit.
- Current problem list.
- Current medication list.
- Current medication allergy list.
- Procedures performed during the visit.
- Immunizations or medications administered during the visit.
- Vital signs taken during the visit (or other recent vital signs).
- Laboratory test results.
- List of diagnostic tests pending.
- Clinical instructions.
- Future appointments.
- Referrals to other providers.
- Future scheduled tests.
- Demographic information maintained within certified electronic health record technology (CEHRT) (sex, race, ethnicity, date of birth, preferred language).
- Smoking status.
- Care plan field(s), including goals and instructions.
- Recommended patient decision aids (if applicable to the visit).
## Protect Electronic Health Information

<table>
<thead>
<tr>
<th>Objective</th>
<th>Protect electronic health information created or maintained by the certified EHR technology (CEHRT) through the implementation of appropriate technical capabilities.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Measure</td>
<td>Conduct or review a security risk analysis in accordance with the requirements under 45 CFR 164.308(a) (1), including addressing the encryption/security of data stored in CEHRT in accordance with requirements under 45 CFR 164.312 (a)(2)(iv) and 45 CFR 164.306(d)(3), and implement security updates as necessary and correct identified security deficiencies as part of the provider's risk management process for EPs.</td>
</tr>
<tr>
<td>Exclusion</td>
<td>No exclusion.</td>
</tr>
</tbody>
</table>
## EPs must select 3 out of the 6:

<table>
<thead>
<tr>
<th>Menu Objective</th>
<th>Measure</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Imaging Results</td>
<td>More than 10% of imaging results are accessible through Certified EHR Technology</td>
</tr>
<tr>
<td>2. Family History</td>
<td>Record family health history for more than 20%</td>
</tr>
<tr>
<td>3. Syndromic Surveillance</td>
<td>Successful ongoing transmission of syndromic surveillance data</td>
</tr>
<tr>
<td>4. Cancer</td>
<td>Successful ongoing transmission of cancer case information</td>
</tr>
<tr>
<td>5. Specialized Registry</td>
<td>Successful ongoing transmission of data to a specialized registry</td>
</tr>
<tr>
<td>6. Progress Notes</td>
<td>Enter an electronic progress note for more than 30% of unique patients</td>
</tr>
</tbody>
</table>
Probably
More than 20 percent of all unique patients seen by the EP, during the EHR reporting period have a structured data entry for one or more first-degree relatives.
### Syndromic Surveillance Data Submission

<table>
<thead>
<tr>
<th>Objective</th>
<th>Measure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Capability to submit electronic syndromic surveillance data to public health agencies except where prohibited, and in accordance with applicable law and practice.</td>
<td>Successful ongoing submission of electronic syndromic surveillance data from CEHRT to a public health agency for the entire EHR reporting period.</td>
</tr>
</tbody>
</table>

### Report Cancer Cases

<table>
<thead>
<tr>
<th>Objective</th>
<th>Measure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Capability to identify and report cancer cases to a public health central cancer registry, except where prohibited, and in accordance with applicable law and practice.</td>
<td>Successful ongoing submission of cancer case information from CEHRT to a public health central cancer registry for the entire EHR reporting period.</td>
</tr>
</tbody>
</table>

### Report Specific Cases

<table>
<thead>
<tr>
<th>Objective</th>
<th>Measure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Capability to identify and report specific cases to a specialized registry (other than a cancer registry), except where prohibited, and in accordance with applicable law and practice.</td>
<td>Successful ongoing submission of specific case information from CEHRT to a specialized registry for the entire EHR reporting period.</td>
</tr>
</tbody>
</table>
The text of the electronic note must be text-searchable and may contain drawings and other content.
Quality Measures

- Eligible Professionals must report on 9 measures
- Choice set is 64 measures in 6 domains
- Reported measures must come from at least 3 domains

- Patient and Family Engagement (4)
- Patient Safety (6)
- Care Coordination (1)
- Efficient Use of Health Resources (4)
- Clinical Process/Effectiveness (40)
- Population/Public Health (9)

© 2012 American Hospital Association
<table>
<thead>
<tr>
<th>Provider</th>
<th>Before 2014</th>
<th>2014 and Beyond</th>
</tr>
</thead>
<tbody>
<tr>
<td>EPs</td>
<td>Complete 6 out of 44</td>
<td>• Complete 9 out of 64</td>
</tr>
<tr>
<td></td>
<td>o 3 core or 3 alternate core</td>
<td>• Choose at least 1 measure in 3 NQS domains*</td>
</tr>
<tr>
<td></td>
<td>o 3 menu</td>
<td>• Recommended core CQM's include:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>o 9 CQM's for the adult population</td>
</tr>
<tr>
<td></td>
<td></td>
<td>o 9 CQM's for the pediatric population Prioritize NQS domains</td>
</tr>
<tr>
<td>EHs and CAHs</td>
<td>Complete 15 out of 15</td>
<td>Complete 16 out of 29</td>
</tr>
<tr>
<td></td>
<td></td>
<td>o Choose at least 1 measure in 3 NQS domains*</td>
</tr>
</tbody>
</table>
## Interventions - Clinical Decision Support

<table>
<thead>
<tr>
<th>Stage 1 Objective</th>
<th>Stage 1 Measure</th>
<th>Stage 2 Objective</th>
<th>Stage 2 Measure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Implement one clinical decision support rule relevant to specialty or high priority along with the ability to track compliance that rule</td>
<td>Implement one clinical decision support rule</td>
<td>Use clinical decision support to improve performance on high-priority health conditions</td>
<td>1. Implement 5 clinical decision support interventions related to 4 or more clinical quality measures, if applicable, at a relevant point in patient care for the entire EHR reporting period.</td>
</tr>
</tbody>
</table>

- **CDS definition/EHR certification**
- **CDS-CQM linkage**
## Clinical Quality Measures

<table>
<thead>
<tr>
<th>NQF Number</th>
<th>Measure Title</th>
<th>Use in other CMS Quality Programs</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>2014 Measures for Patient and Family Engagement</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0384</td>
<td>Oncology: Medical and Radiation—Pain Intensity</td>
<td>EHR PQRS</td>
</tr>
<tr>
<td>TBD</td>
<td>Functional status assessment for knee replacement.</td>
<td></td>
</tr>
<tr>
<td>TBD</td>
<td>Functional status assessment for hip replacement.</td>
<td></td>
</tr>
<tr>
<td>TBD</td>
<td>Functional status assessment for complex chronic conditions</td>
<td></td>
</tr>
<tr>
<td><strong>2014 Measures for Clinical Process / Effectiveness</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0004</td>
<td>Initiation and Engagement of Alcohol and Other Drug Dependence Treatment</td>
<td>EHR PQRS, HEDIS, state use, ACA 2701, NCQA–PCMH Recognition</td>
</tr>
<tr>
<td>0018</td>
<td>Controlling High Blood Pressure</td>
<td>EHR PQRS, ACO, Group Reporting PQRS, UDS.</td>
</tr>
<tr>
<td>0031</td>
<td>Breast Cancer Screening</td>
<td>EHR PQRS, ACA 2701, HEDIS, state use, NCQA–PCMH Recognition</td>
</tr>
<tr>
<td>0032</td>
<td>Cervical Cancer Screening</td>
<td>EHR PQRS, ACA 2701, HEDIS, state use, NCQA–PCMH Recognition, UDS.</td>
</tr>
<tr>
<td>0034</td>
<td>Colorectal Cancer Screening</td>
<td>EHR PQRS, ACO, Group Reporting PQRS, NCQA–PCMH Recognition</td>
</tr>
<tr>
<td>0036</td>
<td>Use of Appropriate Medications for Asthma</td>
<td>EHR PQRS</td>
</tr>
<tr>
<td>0043</td>
<td>Pneumonia Vaccination Status for Older Adults.</td>
<td>EHR PQRS, ACO, Group Reporting PQRS, NCQA–PCMH Recognition</td>
</tr>
<tr>
<td>0055</td>
<td>Diabetes: Eye Exam</td>
<td>EHR PQRS, Group Reporting PQRS</td>
</tr>
</tbody>
</table>

© 2012 American Hospital Association
Drug-drug and drug-allergy alerts required and do not count

If none of the CQMs are applicable to an EP's scope of practice, the EP should implement CDS interventions that he or she believes will drive improvements in the delivery of care for the high-priority health conditions relevant to their patient population.
2014 CQM issues

- www.cms.gov/EHRIncentivePrograms
- ONC does not require vendors to configure their EHRs to measure all 64 CQMs
- 2014 CQMs will be utilized for Stage 1 or Stage 2 reporting
- PFR not PFP
- Multiple reporting options
  - CMS website
  - PQRS
  - Group option
  - Medicaid-state reporting
CDS CQM Strategy

**PRIMARY CARE**
1. Don’t panic
2. EHR 2014 certification for specific CQMs
3. Select 9 CQMs appropriate to practice
   - >=3 Domains
4. Select 5 CDS associated with 4 CQMs
5. Select reporting option.

**SUBSPECIALTIES**
1. Panic!
2. EHR 2014 certification for specific CQMs
3. Search for 9 CQMs
4. Search for 5 CDS
5. Read attestation and reporting requirements
6. FAQ watch
7. Select reporting option.
Physicians Need to Do
Physicians Need to Do

1. Review your EHRs 2014 certified version
   - Upgrade planning
2. Plan for patient portal implementation
3. Identify likely workflow changes
4. Choose 3 “menu” items
5. Choose quality measures and clinical decision supports
6. Delegation (get a really good office manager if you don’t have one)
**AHA Take Away on Stage 2**

<table>
<thead>
<tr>
<th>Positives</th>
<th>Remaining Concerns</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Providers will only need to have the certified EHR technology needed to support their approach to meaningful use in FY/CY 2014 and later.</td>
<td>• Penalties generally based on whether a PPS hospital or physician met meaningful use 2 years prior to the payment year of the penalty.</td>
</tr>
<tr>
<td>• One-year delay in start of Stage 2 and one-quarter/90-day reporting period in FY/CY 2014 helps address timing concerns</td>
<td>• Complexity of requirements that vary with when a provider starts</td>
</tr>
<tr>
<td>• Smaller number of quality measures than proposed</td>
<td>• All providers must use “2014 Edition” certified EHR in FY/CY 2014, regardless of stage</td>
</tr>
</tbody>
</table>
Meaningful Use Audits
Meaningful Use Audits

- It is all or nothing
  - The law doesn’t provide a mechanism for partial incentive if you fail on one or more criteria

- When/If you get audited
  - When you get notice of audit, you will only have ~2 weeks to respond
  - Initial step is a desk audit. If you pass this, you avoid a field audit
    - You don’t want a field audit
  - For the desk audit, there is no human interaction
    - Package your audit materials so that it makes sense to an ‘outsider’
    - Provide the right amount of information – do not invite additional questions from auditors by providing too much or too little information

- Ask your vendor and/or peers for advise based on their experience with MU audits
Meaningful Use Audits

- Meaningful Use audits are a ‘when’ not an ‘if’
- Retain documentation for 6 years post-attestation
- If found to not be eligible for an EHR incentive payment, payment will be recovered
Meaningful Use Audits

- Relevant IT systems, system configurations, roles, and processes for each MU criteria
- System certification documentation (versions, certification #s, etc.)
- Reports/data for each reporting period
- Confirmations or other communication for CMS or State
- A copy of (ONC) certification as well as licensing agreements with the vendor or invoices from the system purchase
- Specific and concise documentation for all Core and Menu Criteria (Numerator/Denominator & Yes/No)
- Reports from your CEHRT to document the numbers you attested to for Numerator/Denominator criteria and Quality Measures
  - Documentation that demonstrates how each criteria was met
    - e.g., screen shots, training materials, reports, audit logs, policies/procedures
  - Be sure there are time/date stamps to prove screen shots, etc. were taken during the reporting period
  - Especially for Yes/No criteria
MEANINGFUL USE Stage 3
Stage 3 – HITPC Meetings

- CPOE – referral and transition
- CDS – use external CDS’s
- Demographics: occupation, sexual orientation/gender identity, disability status
- Code medication allergy
- 15 Clinical Decision Support, track compliance
- Real time dashboards in place of patient lists
- Summary of care sent electronically to 50%
- Patients submit information on family health history, blood pressure, weight, glucose levels, etc.
- Create pre-visit prep tools
- Patients correct their own records
- Information provided in top 5 languages
- 15% of patients securely communicate with providers
- Receive immunization records
- Send records electronically to jurisdictional registries.
Resources

CMS on Stage 2

ONC on Stage 2
http://www.healthit.gov/policy-researchers-implementers/meaningful-use-stage-2

Randi Terry, 231-935-5199, rterry@mhc.net
Joe Cook, 231-935-8013, jcook1@mhc.net
Questions