Understanding the EHR Incentive Final Rule for Eligible Professionals

Meaningful Use Boot Camp

December 1, 2011

Introductions

- Your name
- Where you work
- Your role at your facility
- What you are hoping to learn

Conflict of Interest

- Dr. Kleeberg is the Clinical Director for the North Dakota - Minnesota Regional Extension Assistance Center for HIT (REACH). REACH is a federally subsidized non-profit entity designed to assist Hospitals and Professionals in becoming meaningful users of EHRs. He will be mentioning it in this talk.
- No other conflict of interest

Objectives

- Understand the history behind the Incentives
- Be able to calculate the Medicare and Medicaid incentives for a professional as well as the penalties
- Understand how to register and attest for the incentives
- Identify the criteria and quality measures that will need to be reported to be a “meaningful user”
- Understand how achieving these will impact workflow
- Become familiar with methods for engaging physicians

Outline

- **Background to the Final Rule**
- Financial Incentives
- Knowing if Your EHR is Certified
- Elements of Meaningful Use
- Registration and Attestation
- Quality Measures
- Proposed Stage II Criteria
- Capturing the Information
- Closure

The History: National Academies Reports

1999 "… at least 44,000 and perhaps as many as 98,000 hospitalized Americans die every year from medical errors." *To Err is Human: Building a Safer Health System*

2001 "A concerted national commitment to building information infrastructure is needed to support health care delivery" *Crossing the Quality Chasm*

2007 "Medication errors injure 1.5M people and cost $3.5B per year in the U.S." *Preventing Medication Errors*

2009 "Even in organizations with advanced HIT, it is rarely used to provide clinicians with evidence-based decision support or for data-driven process improvement." *Crossing the Health Care IT Chasm*

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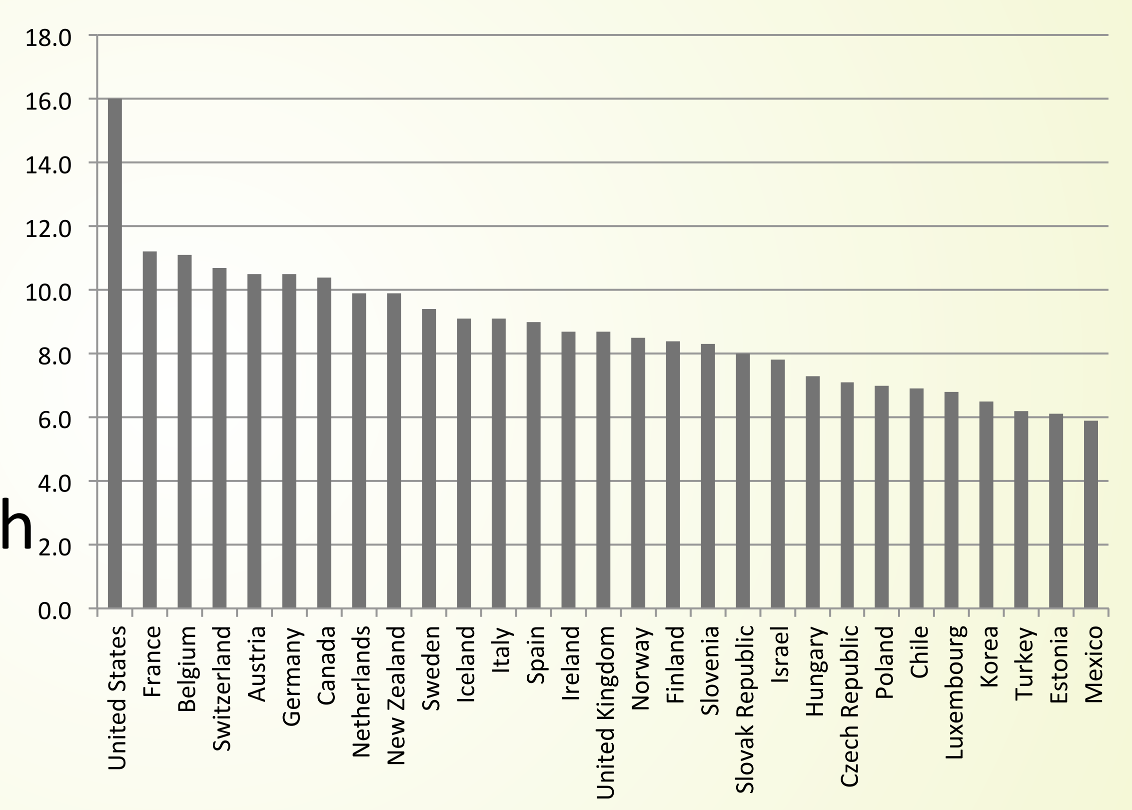
Are we getting value for our dollar? Cost vs. Quality

- Per capita health care spending
  - $2.5T (2009)[1]
  - 17.6% GDP
  - $8,086 per person
- Life expectancy 37th of 191 in quality[2]



[1] CMS Health Expenditures 1960-2009 (http://www.cms.gov/NationalHealthExpendData/downloads/nhegdp09.zip)
[2] World Health Organization Data, 2000 (http://www.who.int/whr)
[3] OECD Health Data 2010: http://www.oecd.org/document/16/0,3343,en_2649_34631_2085200_1_1_1_1,00.html

Underinvestment in HIT

Per Capita Spending on Health Information Technology

	Canada	Germany	Norway	Australia	United States
Per capita spending	$31.85	$21.20	$11.43	$4.93	$0.43

Source: Anderson, G. F., Frogner, B. K., Johns, R. A., & Reinhardt, U. E. (2006). Health Care Spending And Use Of Information Technology In OECD Countries. Health Affairs, 25(3), 819-831.

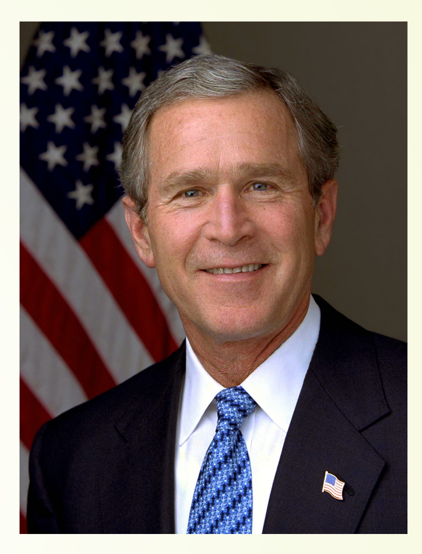
Patients Want More Accessible, Coordinated, Well-Informed Care

Percent reporting it is very important/important that:	Total very important or important
You have easy access to your own medical records	94%
All your doctors have easy access to your medical records	96%
You have information about the quality of care provided by different doctors/ hospitals	95%

Source: Commonwealth Fund Survey of Public Views of the U.S. Health Care System, 2008.

The Bi-Partisan Support:

2004 "…an Electronic Health Record for every American by the year 2014. By computerizing health records, we can avoid dangerous medical mistakes, reduce costs, and improve care." George W Bush - State of the Union address, Jan. 20, 2004



2009 "Computerize all health records within five years." Barack Obama - George Mason University, January 12, 2009

Placing our Bet on HIT: The "Stimulus Package"

- The stimulus package (Feb 2009)
  - American Recovery and Reinvestment Act (ARRA) - $787 B
  - Health Information Technology for Economic and Clinical Health (HITECH) Act
    - $29.2 B ($17.2 B net) starting in 2011 to incent Medicare- and Medicaid-participating physicians and hospitals to use certified EHR systems in a "meaningful" way

Meaningful Use Overview: Statutory Framework

In HITECH, Congress established three fundamental criteria of requirements for meaningful use:

1. Use of certified EHR technology in a meaningful manner
2. Certified EHR technology is connected in a manner that provides for the electronic exchange of health information to improve the quality and coordination of care
3. In using certified EHR technology, the provider submits clinical quality measures and other measures as determined by the secretary

Source: Brian Wagner, Senior Director of Policy and Public Affairs, eHealth Initiative (eHI) presentation to the MN Exchange and Meaningful Use Workgroup January 15, 2010

The HITECH Act's Framework

Regional extension centers
Workforce training
Adoption of EHRs
Medicare and Medicaid incentives and penalties
Meaningful use of EHRs
Improved individual and population health outcomes
Increased transparency and efficiency
Improved ability to study and improve care delivery
State grants for health information exchange
Standards and certification framework
Privacy and security framework
Exchange of health information
Research to enhance HIT

Blumenthal D. Launching HITECH. N Engl J Med posted online Dec 30 2009. http://healthcarereform.nejm.org/?p=2669

Aligning Certification and Standards

Meaningful Use Objectives	Standards	Certification Criteria
E-Rx	NCPDP SCRIPT 8.1/10.6 must be used	Capability to E-Rx must be included
Provide Patient Summary Record	Continuity of Care Document (CCD) or Continuity of Care Record (CCR) must be used plus vocabulary standards	Capability to electronically transmit a patient summary record must be included
Electronically Submit Data to Immunization Registries	HL7 2.5.1 or HL7 2.3.1 and CVX Code Set	Capability to electronically transmit immunization data must be included

Source: Farzad Mostashari, ONC Presentation to HIT Policy Committee January 13, 2010

The Final Rule

- Recommendations from the Office of the National Coordinator of Health Information Technology (ONC formally known as ONCHIT) Policy Committee-July 16, 2009
- CMS released the Medicare & Medicaid Electronic Health Record (EHR) Incentive Program Notice of Proposed Rulemaking (NPRM) –January 13, 2010
  - CMS received 2,000+ comments in the 3 month comment period
- Final Rule Published –July 28, 2010

Outline

- Background to the Final Rule
- **Financial Incentives for Professionals**
- Knowing if Your EHR is Certified
- Elements of Meaningful Use
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Incentive Payments to Eligible Professionals

- Made either directly to the professional or the professional may reassign it to another entity
- Professionals who work in multiple sites and achieve MU by combining the work they did at multiple sites, still may only assign their payment to one entity
- Under Medicare the payment for the first year of demonstrating MU, will be made when the professional reaches his/her allowable charges limit or the end of the year, whichever comes first

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Incentive Program Key Provisions

Eligibility

- Eligible professionals must choose between Medicare & Medicaid Incentives, but may switch once

Timeframe for Demonstrating Meaningful Use (MU):

- In the 1st year of demonstrating meaningful use, each provider must demonstrate MU over any continuous 90 period.
  - Note: This could be the second payment year if money was received from Medicaid for adopt, implement, upgrade
- For subsequent years, individual professionals must demonstrate MU over the entire reporting year.

Definition of a Medicare Eligible Professional

- A physician, defined by the Social Security Act Sec 1861(r):
  - A doctor of medicine or osteopathy
  - A doctor of dental surgery or dental medicine
  - A doctor of podiatric medicine
  - A doctor of optometry
  - A chiropractor
- Does not provide more than 90% of services with a place of service (POS) code of 21 or 23 (considered hospital inpatient or ED based)
- If at multiple sites, must have certified EHR technology available for ≥ 50% of their patient encounters
- Incentive amount is 75% of the physician's Medicare part B allowable RBRVS charges up to the payment year limit
  - Medicare Advantage plan charges are excluded from the calculation
  - Professional services rendered in RHCs and hospital owned clinics using provider based billing are excluded from the calculation

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Maximum Medicare Incentives for EPs in a non shortage area[1]

2010	2011	2012	2013	2014	2015	2016	2017	Total
	Stage 1 $18k	Stage 1 $12k	Stage 1? $8k	Stage 2 $4k	TBD $2k	TBD	TBD	$44k
		Stage 1 $18k	Stage 1 $12k	Stage 2 $8k	TBD $4k	TBD $2k	TBD	$44k
			Stage 1 $15k	Stage 1 $12k	TBD $8k	TBD $4k	TBD	$39k
				Stage 1 $12k	TBD $8k	TBD $4k	TBD	$24k
					TBD	TBD	TBD	0
Penalty (deduction from Medicare charges) if not at stage 3 by January 1 of that year:					**1%**	**2%**	**3%**	

1. Professionals with >50% Medicare services (as opposed to charges) in a health professional shortage area see a 10% increase in the maximum payment

Medicaid Eligible Professional

- An Eligible Professional for Medicaid is defined in statute as a
  - Physician (MD, DO and in some states, optometrists)
  - Dentist
  - Certified nurse mid-wife
  - Nurse practitioner
  - Physician assistant if the assistant is practicing in either a rural health clinic (RHC) or a federally qualified health center (FQHC) that is led by a physician assistant
- PA would be leading an FQHC or RHC if:
  - A PA is the primary provider in a clinic (for example, when there is a part-time physician and full-time PA, we would consider the PA as the primary provider)
  - A PA is a clinical or medical director at a clinical site of practice
  - A PA is an owner of an RHC
- A PA is ineligible for Medicaid in North Dakota BUT is eligible for the incentive if the above are met

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Medicaid Eligible Professional, cont.

- In order to be eligible for the Medicaid incentives, one must have
  - Greater than 30% Medicaid patient volume
  - Greater than 20% if a pediatrician (physician)
  - Greater than 30% "needy individuals" if > 50% encounters at an FQHC or RHC.
    - The Social Security Act defines a needy individual[1] as one who
      - Is receiving assistance under Medicaid
      - Is receiving assistance under title XXI the State Child Health Insurance Program (SCHIP)
      - Is furnished uncompensated care by the professional;
      - Has charges reduced by the professional based on ability to pay.

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1. http://www.socialsecurity.gov/OP_Home/ssact/title19/1903.htm#act-1903-t-3-f

EP Medicaid Volume Calculation

- Calculated by encounters not charges
  - Volume can be calculated by clinic in most instances
  - No minimum patient volume required
- Numerator: Services rendered on any one day to an individual where Medicaid or a Medicaid demonstration project under section 1115 of the Act paid
  - for part or all of the service; or
  - all or part of their premiums, copayments, and/or cost-sharing.
- Denominator: All encounters

Calculating Eligible Professional Medicaid Incentives

- Any provider who has the patient mix to be eligible for Medicaid will be assumed to have met the cost threshold required for the incentive.
- Consequently, for professionals with >30% Medicaid patient mix, the incentive amount is:
  - $21,250 for the first payment year
  - $8500 for each of the following 5 years
- For pediatric physicians with between 20% and 30% Medicaid, the incentive amount is one third lower:
  - $14,167 in the first payment year
  - $5,667 for each of the following 5 years
- The first payment year can be as late as 2016

Medicaid: 1st Payment Year For "Adopt, Implement, Upgrade"

- Eligible professionals can receive incentives for adoption, implementation and upgrade of certified EHR technology in their first year of participation
- "Adopt, implement, or upgrade" means:
  - Install or commence utilization of certified EHR technology capable of meeting meaningful use requirements; or
  - Expand the functionality of certified EHR technology capable of meeting meaningful use requirements at the practice site, including staffing, maintenance, and training.
  - Upgrade from existing EHR technology to certified EHR technology per the ONC EHR certification criteria.

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Maximum Medicaid Incentives for EPs with ≥ 30% volume

		Year of Adopt, implement, Upgrade or MU Demonstration						
		2011	2012	2013	2014	2015	2016	2011
Calendar Year	2011	$21,250						$21,250
	2012	$8,500	$21,250					
	2013	$8,500	$8,500	$21,250				$8,500
	2014	$8,500	$8,500	$8,500	$21,250			
	2015	$8,500	$8,500	$8,500	$8,500	$21,250		$8,500
	2016	$8,500	$8,500	$8,500	$8,500	$8,500	$21,250	$8,500
	2017		$8,500	$8,500	$8,500	$8,500	$8,500	
	2018			$8,500	$8,500	$8,500	$8,500	
	2019				$8,500	$8,500	$8,500	$8,500
	2020					$8,500	$8,500	
	2021						$8,500	$8,500
	Total	$63,750	$63,750	$63,750	$63,750	$63,750	$63,750	$63,750

Notable Differences Between the Medicare & Medicaid Incentives

	Medicare	Medicaid
Reimbursement for eligible professionals	Based on Medicare Part B allowed charges	Based on patient mix (EHR cost assumed)
Types of eligible professionals	Physicians, dentists, podiatrists, optometrists, chiropractor	Physicians, dentists, nurse midwife, nurse practitioner and some PAs
First payment year	Demonstrate meaningful use over a continuous 90 days in the calendar year	Can be for adopt, implement or upgrade only
Subsequent payment years	Must be consecutive	Needn't be consecutive for EPs
Payments	No payments for years after 2016	Payments can start as late as 2016 and no payments after 2021
Penalties if not a MUser	Yes	No
Consistent across nation	Yes	States choose to implement

Deciding Between Medicare and Medicaid

- For professionals eligible for both programs, the incentive is greater under Medicaid than Medicare
- If the professional's patient population drops below the Medicaid threshold they are eligible to switch but that can only occur once during the program
- Any payment year skipped in the Medicaid program would be counted as a payment year in the Medicare program if the professional switches resulting in loss payment years

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Small Groups

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How do you know if your EHR is Certified?

- To achieve Meaningful Use, one must use a ONC Authorized Testing and Certification Body (ONC-ATCB) certified EHR
- Listings of the EHRs and what they certified upon can be found at:
  - http://healthit.hhs.gov/chpl
- This is what you will find…

ONC Certified EHR Products List

The Certified HIT Product List (CHPL) provides the authoritative, comprehensive listing of Complete EHRs and EHR Modules that have been tested and certified under the Temporary Certification Program maintained by the Office of the National Coordinator for Health IT (ONC). Each Complete EHR and EHR Module listed below has been certified by an ONC-Authorized Testing and Certification Body (ONC-ATCB) and reported to ONC. Only the product versions that are included on the CHPL are certified under the ONC Temporary Certification Program.

Please send suggestions and comments regarding the Certified Health IT Product List (CHPL) to ONC.certification@hhs.gov, with "CHPL" in the subject line.

Vendors or developers with questions about their product's listing should contact the ONC-Authorized Testing and Certification Body (ONC-ATCB) that certified their product.

USING THE CHPL WEBSITE

To browse the CHPL and review the comprehensive listing of certified products, follow the steps outlined below:

1. Select your practice type by selecting the Ambulatory or Inpatient buttons below
2. Select the "Browse" button to view the list of CHPL products

To obtain a CMS EHR Certification ID, follow the steps outlined below:

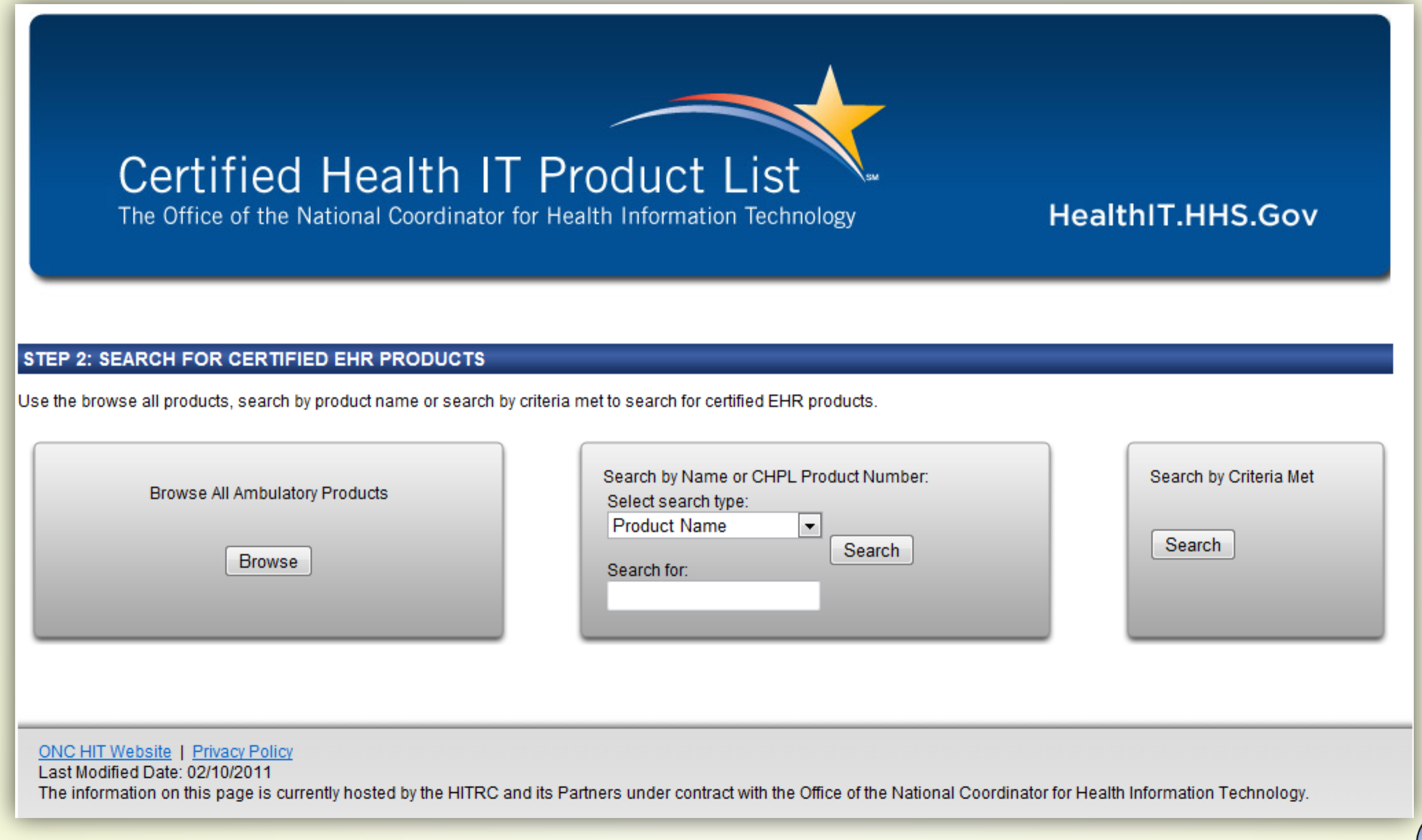
1. Select your practice type by selecting the Ambulatory or Inpatient buttons below
2. Search for EHR Products by browsing all products, searching by product name or searching by criteria met
3. Add product(s) to your cart to determine if your product(s) meet 100% of the required criteria
4. Request a CMS EHR Certification ID for CMS registration or attestation from your cart page

STEP 1: SELECT YOUR PRACTICE TYPE

Ambulatory Practice Type | Inpatient Practice Type

ONC HIT Website | Privacy Policy
Last Modified Date: 12/23/2010
The information on this page is currently hosted by the HITRC and its Partners under contract with the Office of the National Coordinator for Health Information Technology.

Choice to Search or Browse



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Using Browse…

Your Search Results: Showing 1-25 of 809 Products Found

STEP 3: ADD PRODUCTS TO YOUR CART

To add products to your cart, select the "Add to Cart" link in the far-right column. After adding a product to your cart, you will be directed to your cart page. Once on the cart page you can view the criteria met by the product(s) in your cart. Once the product(s) in your cart meet 100% of the required criteria you can obtain a CMS EHR Certification ID.

You can sort on any column in the table below. To sort, click on the column header and the arrow will confirm you are sorting in ascending or descending order.

Matching Product			See Complete Products Only			
Certifying ATCB	Vendor	Product	Product Version#	Product Classification	Additional Software Required	
InfoGard	Darena Solutions LLC	1 Connect HePoEx EHR	2011	Modular EHR	Microsoft Online Services, Microsoft InfoPath 2010; all applicable requirements	Add to Cart
InfoGard	Darena Solutions LLC	1 Connect HePoEx EHR	2.5	Modular EHR	Microsoft Online Services, Microsoft InfoPath 2010; all applicable requirements	Add to Cart
Drummond Group Inc.	PCC Physician's Computer Company - Pediatric Software	2011 PCC EHR Pediatric Charting	V3.0	Modular EHR	DrFirst Rcopia; 7-Zip	Add to Cart
InfoGard	Doctor Office Management, Inc.	2011 PhysicianXpress	1.0	Complete EHR	N/A	Add to Cart
CCHIT	Pulse Systems	2011 Pulse Complete EHR	2011	Complete EHR		Add to Cart
Drummond Group Inc.	Systemedx Inc.	2011 Systemedx Clinical Navigator	2011.03	Complete EHR	Email for exchanging patient summary records	Add to Cart
CCHIT	Waiting Room Solutions	2011 Waiting Room Solutions Web Based EHR and Practice Management System	4.0	Complete EHR	7-Zip;SureScripts	Add to Cart
CCHIT	Health Communication Systems, LLC	2011-14 DirectorMD EHR	10.0	Complete EHR	DirectorMD Patient Portal;DirectorMD (HIE) Health Information Engine	Add to Cart
Drummond Group Inc.	UnisonCare Corporation	2011-2012 Certified UniCharts EMR	version 3	Complete EHR	Allscripts ePrescribe, Email software	Add to Cart
Drummond Group Inc.	VipaHealth Solutions, LLC	24 7 smartEMR	5.1.2	Complete EHR		Add to Cart
InfoGard	Medaxis Corporation	360EHR	2.12	Complete EHR	WinSCP 4.2.9 – §170.302 (v), Java SE 6 – all applicable requirements, Java Web Start 1.6 – all applicable requirements	Add to Cart
CCHIT	4Medica	4medica Ambulatory Cloud iEHR (Integrated Electronic Health Record) with 4medica's Integration Engine to connect Ambulatory EMRs	10.4	Modular EHR		Add to Cart
CCHIT	4Medica	4medica Ambulatory Cloud iEHR (Integrated Electronic Health Record) with 4medica's Integration Engine to connect Ambulatory EMRs	10.4	Modular EHR		Add to Cart
CCHIT	4Medica	4medica Ambulatory Cloud iEHR (Integrated Electronic Health record) with 4medica's Integration Engine to connect Ambulatory EMRs	10.4	Modular EHR		Add to Cart

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The Shopping Cart…

STEP 4: REQUEST CMS EHR CERTIFICATION ID

Certification Bar Summary

The bar below provides a summary of the criteria that are met by items in your cart. Criteria highlighted in blue have been met by products in the cart, criteria in gray have not.

Note: Certification criterion 170.302(w) is optional for the purposes of certification. If w is gray in the bar below, the product(s) in your cart can still meet 100% of the required certification criteria.

Place your mouse over the individual letters to learn more about each criterion.

General Criteria (170.302)

a b c d e f g h i j k l m n o p q r s t u v w

Ambulatory Criteria (170.304)

a b c d e f g h i j

Requesting Your CMS EHR Certification ID

If the products in your cart meet 100% of the required criteria, you can now obtain a CMS EHR Certification ID.

If the products in you cart do not meet 100% of the required criteria, select the "Return to Search" link and continue adding products to your cart until your cart meets 100% of the required criteria.

Get CMS EHR Certification ID

Percentage of criteria currently met:28%

PRODUCTS IN CART

Certifying ATCB	Vendor	Product	Product Version #	Product Classification	Additional Software Required	
			2011	Modular EHR	Microsoft Online Services, Microsoft InfoPath 2010; all applicable requirements	Remove

Certified Product Details

CERTIFICATION CRITERIA DETAIL VIEW

Complete EHR 2011

Certifying ATCB: CCHIT | CHPL Product Number: CC-1112-946
Classification: Complete EHR | Practice Setting:Ambulatory
Additional Software Required:

General Criteria (170.302)

- ✓ (a) Drug-drug, drug-allergy interaction checks
- ✓ (b) Drug formulary checks
- ✓ (c) Maintain up-to-date problem list
- ✓ (d) Maintain active medication list
- ✓ (e) Maintain active medication allergy list
- ✓ (f) Record and chart vital signs
- ✓ (g) Smoking status
- ✓ (h) Incorporate laboratory test results
- ✓ (i) Generate patient lists
- ✓ (j) Medication reconciliation
- ✓ (k) Submission to immunization registries
- ✓ (l) Public health surveillance
- ✓ (m) Patient specific education resources
- ✓ (n) Automated measure calculation
- ✓ (o) Access control
- ✓ (p) Emergency access
- ✓ (q) Automatic log-off
- ✓ (r) Audit log
- ✓ (s) Integrity
- ✓ (t) Authentication
- ✓ (u) General encryption
- ✓ (v) Encryption when exchanging electronic health information
- ✓ (w) Accounting of disclosures (optional)

Ambulatory Criteria (170.304)

- ✓ (a) Computerized provider order entry
- ✓ (b) Electronic prescribing
- ✓ (c) Record demographics
- ✓ (d) Patient reminders
- ✓ (e) Clinical decision support
- ✓ (f) Electronic copy of health information
- ✓ (g) Timely access
- ✓ (h) Clinical summaries
- ✓ (i) Exchange clinical information and patient summary record
- ✓ (j) Calculate and submit clinical quality measures

Criteria Descriptions

General Criteria (170.302) | Ambulatory Criteria (170.304) | Ambulatory Clinical Quality Measures | Inpatient Criteria (170.306) | Inpatient Clinical Quality Measures

General Criteria (170.302)

(a) **Drug-drug, drug-allergy interaction checks**
Drug-drug, drug-allergy interaction checks. (1) Notifications. Automatically and electronically generate and indicate in real-time, notifications at the point of care for drug-drug and drug-allergy contraindications based on medication list, medication allergy list, and computerized provider order entry (CPOE). (2) Adjustments. Provide certain users with the ability to adjust notifications provided for drug-drug and drug-allergy interaction checks.

(b) **Drug formulary checks**
Drug formulary checks. Enable a user to electronically check if drugs are in a formulary or preferred drug list.

(c) **Maintain up-to-date problem list**
Maintain up-to-date problem list. Enable a user to electronically record, modify, and retrieve a patient's problem list for longitudinal care in accordance with: (1) The standard specified in §170.207(a)(1); or (2) At a minimum, the version of the standard specified in §170.207(a)(2).

(d) **Maintain active medication list**
Maintain active medication list. Enable a user to electronically record, modify, and retrieve a patient's active medication list as well as medication history for longitudinal care.

(e) **Maintain active medication allergy list**
Maintain active medication allergy list. Enable a user to electronically record, modify, and retrieve a patient's active medication allergy list as well as medication allergy history for longitudinal care.

(f) **Record and chart vital signs**
170.302(f)(1) Record and Chart Vital signs. Enable a user to electronically record, modify, and retrieve a patient's vital signs including, at a minimum, the height, weight, and blood pressure. 170.302(f)(2) Calculate Body mass index. Automatically calculate and display body mass index (BMI) based on a patient's height and weight. 170.302(f)(3) Plot and display growth charts. Plot and electronically display, upon request, growth charts for patients 2-20 years old.

(g) **Smoking status**
Smoking status. Enable a user to electronically record, modify, and retrieve the smoking status of a patient. Smoking status types must include: current every day smoker; current some day smoker; former smoker; never smoker; smoker, current status unknown; unknown if ever smoked.

(h) **Incorporate laboratory test results**
Incorporate laboratory test results. 1) Receive results. Electronically receive clinical laboratory test results in a structured format and display such results in human readable format. 2) Display test report information. Electronically display all the information for a test report specified at 42 CFR 493.1291(c)(1) through (7). 3) Incorporate results. Electronically attribute, associate, or link a laboratory test result to a laboratory order or patient record.

Quality Measures Certified

Ambulatory Clinical Quality Measures

- [ ] NQF 0001 Asthma Assesment
- [ ] NQF 0002 Pharyngitis- Children
- [ ] NQF 0004 Alcohol and Drug Dependence
- [ ] NQF 0012 Prenatal Care: HIV Screening
- [x] NQF 0013 Hypertension: Blood Pressure Measurement
- [ ] NQF 0014 Prenatal Care: Anti-D immune Globulin
- [ ] NQF 0018 Controlling High Blood Pressure
- [x] NQF 0024 Youth Weight Assesment
- [x] NQF 0027 Tobacco Use Cessation
- [x] NQF 0028 Prevenitive Care: Tobacco Use Assesment and Cessation
- [ ] NQF 0031 Breat Cancer Screening
- [ ] NQF 0032 Cervical Cancer Screening
- [ ] NQF 0033 Chlamydia Screening for Women
- [ ] NQF 0034 Colorectal Cancer Screening
- [ ] NQF 0036 Appropriate Medications for Asthma
- [x] NQF 0038 Childhood Immunization Status
- [x] NQF 0041 Influenza Immunization
- [ ] NQF 0043 Pnemonia Vaccination
- [ ] NQF 0047 Asthma Pharmacologic Therapy
- [ ] NQF 0052 Use of Imaging Study: Low Back Pain
- [x] NQF 0055 Diabetes: Eye Exam
- [ ] NQF 0056 Diabetes: Foot Exam
- [ ] NQF 0059 Diabetes Control: Hemoglobin A1c >9.0%
- [ ] NQF 0061 Diabetic Patients who elevated mmhg V140/90
- [ ] NQF 0062 Nephropathy Screening- Urine
- [ ] NQF 0064 Diabetes Control: LDL < 100mg/dl
- [ ] NQF 0067 Antiplatelet Therapy
- [ ] NQF 0068 Ischemic Vascular Disease: Asparin or other Antithrombotic
- [ ] NQF 0070 Coronoary Artery Disease: Beta Blocker Therapy Post Myocadial Infarction
- [ ] NQF 0073 Blood Pressure Management: Ischemic Valve Disease
- [ ] NQF 0074 Corinary Artery Disease: Lipid Lowering Therapy
- [ ] NQF 0075 IVD: Complete Lipid Panel and LDL Control
- [ ] NQF 0081 Heart Failure: ACE/ ARB Therapy For LVSD (LVEF <40%)
- [ ] NQF 0083 Heart Failure: Beta Blocker for LVSD
- [ ] NQF 0084 Heart Failure: Warfarin Therapy
- [ ] NQF 0086 Primary Open Angle Glaucoma
- [ ] NQF 0088 Diabetic Retinopathy: Macular Edema
- [ ] NQF 0089 Diabetes Management: Retinopathy Screening
- [ ] NQF 0105 Depression Management
- [ ] NQF 0385 Colon Cancer: Chemotherapy
- [ ] NQF 0387 Breast Cancer: Hormonal Therapy
- [ ] NQF 0389 Prostate Cancer: Avoid overuse of Bone Scan
- [x] NQF 0421 Adult Weight Screening
- [x] NQF 0575 Diabetes Control: Hemoglobin A1c <8.0%

Vs.

Ambulatory Clinical Quality Measures

- [x] NQF 0001 Asthma Assesment
- [x] NQF 0002 Pharyngitis- Children
- [x] NQF 0004 Alcohol and Drug Dependence
- [x] NQF 0012 Prenatal Care: HIV Screening
- [x] NQF 0013 Hypertension: Blood Pressure Measurement
- [x] NQF 0014 Prenatal Care: Anti-D immune Globulin
- [x] NQF 0018 Controlling High Blood Pressure
- [x] NQF 0024 Youth Weight Assesment
- [x] NQF 0027 Tobacco Use Cessation
- [x] NQF 0028 Prevenitive Care: Tobacco Use Assesment and Cessation
- [x] NQF 0031 Breat Cancer Screening
- [x] NQF 0032 Cervical Cancer Screening
- [x] NQF 0033 Chlamydia Screening for Women
- [x] NQF 0034 Colorectal Cancer Screening
- [x] NQF 0036 Appropriate Medications for Asthma
- [x] NQF 0038 Childhood Immunization Status
- [x] NQF 0041 Influenza Immunization
- [x] NQF 0043 Pnemonia Vaccination
- [x] NQF 0047 Asthma Pharmacologic Therapy
- [x] NQF 0052 Use of Imaging Study: Low Back Pain
- [x] NQF 0055 Diabetes: Eye Exam
- [x] NQF 0056 Diabetes: Foot Exam
- [x] NQF 0059 Diabetes Control: Hemoglobin A1c >9.0%
- [x] NQF 0061 Diabetic Patients who elevated mmhg V140/90
- [x] NQF 0062 Nephropathy Screening- Urine
- [x] NQF 0064 Diabetes Control: LDL < 100mg/dl
- [x] NQF 0067 Antiplatelet Therapy
- [x] NQF 0068 Ischemic Vascular Disease: Asparin or other Antithrombotic
- [x] NQF 0070 Coronoary Artery Disease: Beta Blocker Therapy Post Myocadial Infarction
- [x] NQF 0073 Blood Pressure Management: Ischemic Valve Disease
- [x] NQF 0074 Corinary Artery Disease: Lipid Lowering Therapy
- [x] NQF 0075 IVD: Complete Lipid Panel and LDL Control
- [x] NQF 0081 Heart Failure: ACE/ ARB Therapy For LVSD (LVEF <40%)
- [x] NQF 0083 Heart Failure: Beta Blocker for LVSD
- [x] NQF 0084 Heart Failure: Warfarin Therapy
- [x] NQF 0086 Primary Open Angle Glaucoma
- [x] NQF 0088 Diabetic Retinopathy: Macular Edema
- [x] NQF 0089 Diabetes Management: Retinopathy Screening
- [x] NQF 0105 Depression Management
- [x] NQF 0385 Colon Cancer: Chemotherapy
- [x] NQF 0387 Breast Cancer: Hormonal Therapy
- [x] NQF 0389 Prostate Cancer: Avoid overuse of Bone Scan
- [x] NQF 0421 Adult Weight Screening
- [x] NQF 0575 Diabetes Control: Hemoglobin A1c <8.0%

Outline

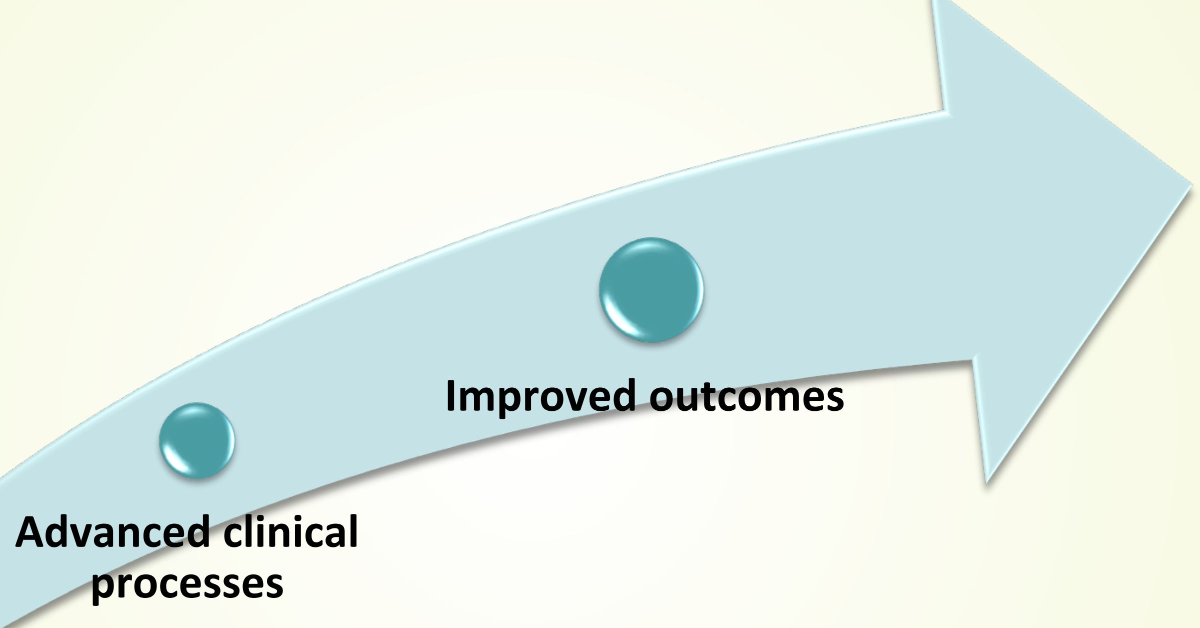
- Background to the Final Rule
- Financial Incentives for Professionals
- Knowing if Your EHR is Certified
- **Elements of Meaningful Use**
- Registration and Attestation
- Quality Measures
- Proposed Stage II Criteria
- Capturing the Information
- Closure

Meaningful Use Criteria

- Adapted from National Priorities and Goals of the National Priorities Partnership:[1]
  - Improving quality, safety, efficiency, and reducing health disparities
  - Engage patients and families in their health care
  - Improve care coordination
  - Improve population and public health
  - Ensure adequate privacy and security protections for personal health information
- Are divided into Core Criteria and Menu Criteria

1. National Priorities Partnership. National Priorities and Goals: Aligning Our Efforts to Transform America's Healthcare. Washington, DC: National Quality Forum; 2008.

Bending the Curve Towards Transformed Health



"Phased-in series of improved clinical data capture supporting more rigorous and robust quality measurement and improvement."

2011 2013 2015

Source: Connecting for Health, Markle Foundation "Achieving the Health IT Objectives of the American Recovery and Reinvestment Act" April 2009

Vision of How EHR Core Functionalities Lay the Foundation for Better Outcomes

BETTER OUTCOMES

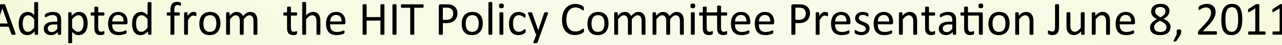
Benchmark | Improve Quality

KEY PROCESS FUNCTIONALITY

Care Coordination | Quality Measurement

ELECTRONIC INFORMATION INFRASTRUCTURE

MU of EHRs | HIE | Data Liquidity



Medicaid Considerations

- State Medicaid Agencies may propose an alternative definition of meaningful use for Medicaid incentives, however...
  - States cannot propose fewer or less rigorous criteria
  - States cannot propose anything that would require additional functionality beyond that of certified EHR technology
  - CMS must approve Medicaid Agencies' proposed definitions

“Stage 1” Meaningful Use Criteria

- 25 objectives and measures for eligible professionals (EP)
  - 15 are required (“core”), up to 5 of the remaining 10 may be deferred to Stage 2 (“menu”)
  - 9 require yes/no attestation; 16 require data submission
- To meet certain objectives/measures, 80% of all patients seen during the reporting period must have certain data elements in the certified EHR technology

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Core and Menu Criteria

- Professionals must complete each of the core criteria unless unable to due to scope of practice, population served or number in the denominator. For example:
  - Chiropractor and e-prescribing
  - Dentists and immunizations

Core Criteria (page 1 of 3)

	Objective	Ambulatory Measure
Improve quality, safety, efficiency and reduce health disparities	CPOE[3] (Lic HC Prof)	>30% of patients on any meds with ≥ one CPOE med order (n/d EHR)[1]
	Drug (D-A, D-D) Interactions	Turned on (y/n)
	ePrescribe[3]	>40% of permissible scripts (n/d EHR)[1]
	Demographics	>50% of patients seen: language, gender, race, ethnicity, DOB (n/d all)[2]
	Problem List	>80% of patients seen at least one or "none" *as structured data* (n/d all)[2]
	Med List	
	Med Allergies	

1. (n/d EHR): Numerator divided by denominator of all unique patients seen during the measurement period whose records are maintained in a certified EHR
2. (n/d all): Numerator divided by denominator of all unique patients seen during the measurement period
3. CPOE and ePrescribe excluded if < 100 scripts written

Core Criteria (page 2 of 3)

	Objective	Ambulatory Measure
Improve quality, safety, efficiency and reduce health disparities	Vitals[2]	>50% of patients ≥ 2yo seen: height, weight, BP, BMI, & for age 2-20: growth charts w/BMI (n/d EHR)[1]
	Smoking	>50% of patients ≥ 13yo seen, record status *as structured data* (n/d EHR)[1]
	Decision Support	1 CDS rule relevant to the specialty specific quality metric *with the ability to track compliance* (y/n)
	Quality Reporting	Report ambulatory quality measures to CMS or states (y/n) 2011: Attest numerator/denominator 2012: Electronic submission

1. (n/d EHR): Numerator divided by denominator of all unique patients seen during the measurement period whose records are maintained in a certified EHR
2. Exclusion if pts ht, wt, & BP have no relevance to scope of practice

Core Criteria (page 3 of 3)

	Objective	Ambulatory Measure
Engage Patients and Families in Their Health Care	eHealth summary	>50% of patients who request it (incl: test results, prob list, med list, med allergies) w/i 3 business days (n/d EHR)[1]
	Clinical summaries	>50% of office visits, a patient gets a visit summary within 3 business days (n/d EHR)[1]
Improve Care Coordination	Exchange with providers[2]	Capability of electronic exchange of key information (Ex: prob list, med list, allergies, test results[3]). One test per measurement period (y/n)
Privacy/security protections for PHI	Protect Patient Personal Health Information	Conduct or review a security risk analysis per 45 CFR 164.308 (a)(1) and correct deficiencies (y/n)

1. (n/d EHR): Numerator divided by denominator of all unique patients seen during the measurement period whose records are maintained in a certified EHR
2. Clinical information must be sent between different legal entities with distinct certified EHR technology or other system that can accept the information and not between organizations that share certified EHR technology
3. "Diagnostic test results " are all data needed to diagnose and treat disease, such as blood tests, microbiology, urinalysis, pathology tests, radiology, cardiac imaging, nuclear medicine tests, and pulmonary function tests.

Menu Criteria

- Professionals may defer up to 5 of the menu criteria until stage 2
- At least one of the criteria from population and public health must be included in order to qualify as a meaningful user
- If a professional is unable to complete one of the menu items due to scope of practice, they may still defer 5 menu items
- States can seek CMS prior approval to require 4 MU criteria be core for their Medicaid professionals:
  - Generate lists of patients by specific conditions
  - Reporting to immunization registries, reportable lab results, and syndromic surveillance

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Menu Criteria (page 1 of 2)

	Objective	Ambulatory Measure
Improve quality, safety, efficiency and reduce health disparities	Formularies	Implement drug formulary checks with at least one internal or external formulary (y/n)
	Lab Results	>40% of labs with numeric or +/- result in chart as structured data (n/d EHR)[1]
	Patient Lists[2]	Generate at least one pt lists based on a specific condition (y/n)
	Reminders	>20% of active pts ≥ 65 or ≤ 5yo sent reminders for follow up care (n/d EHR)[1]
Engage Patients and Families in Their Health Care	eAccess	>10% patients seen with electronic access to lab results, prob lists, med list, med allergies w/i 4 business days of it being updated in the EHR (n/d all)[3]
	Patient Ed	>10% patients seen provided with ed resources identified with the EHR (n/d all)[3]

1. (n/d EHR): Numerator divided by denominator of all unique patients seen during the measurement period whose records are maintained in a certified EHR
2. States may seek approval from CMS to require a specific condition be tracked for Medicare
3. (n/d all): Numerator divided by denominator of all unique patients seen during the measurement period

Menu Criteria (page 2 of 2)

	Objective	Ambulatory Measure
Improve Care Coordination	Medication reconciliation	>50% of transitions of care or a relevant encounter (n/d EHR)[1]
	Summary care record	>50% of referrals and transitions of care[1] (n/d EHR)[1]
Improve Population and Public Heath[2]	Immunization Records[3]	≥ 1 test of submission to state immunization registry (unless no registries are capable) with continued submission if successful (y/n)
	Syndromic Surveillance[3]	≥ 1 test of submission to public health (unless no ph agency is capable) with continued submission if successful (y/n)

1. (n/d EHR): Numerator divided by denominator of all unique patients seen during the measurement period whose records are maintained in a certified EHR
2. Unless an EP, eligible hospital or CAH has an exception for all of these objectives and measures they must complete at least one in this group as part of their demonstration of a meaningful EHR use to be eligible for incentives.
3. States may specify how to test the data submission and to which specific destination

Criteria:

Core:

All Patients:

- Demographics
- Problem list
- Medication list
- Medication allergy list

EHR Patients:

- CPOE
- E-Prescribing
- Vital signs
- Smoking status
- E-copy of their health information
- Clinical summaries

On (Yes or No):

- Clinical Quality Measures
- Drug (D-A, D-D) Interactions
- One clinical decision support rule
- Electronically exchange key clinical information
- Protect electronic health information

Menu:

All Patients:

- E-access to their health information
- Provide patient-specific education resources

EHR Patients:

- Labs as structured data
- Patient reminders
- medication reconciliation
- Summary of care record

On (Yes or No):

- Drug - formulary checks
- Patient list by specific condition
- Test of submission of electronic data to immunization registries. *
- Test of providing electronic syndromic surveillance data to public health agencies. *

* At least 1 public health objective must be selected

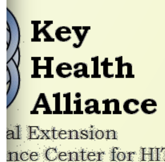
Meaningful Use Specification Sheet

- The authoritative source on MU Criteria
- Downloadable PDF index that links to the details online:
  - http://www.cms.gov/EHRIncentivePrograms/Downloads/EP-MU-TOC.pdf
- Updated by CMS to account for any corrections or changes
- Includes relevant FAQs

Professional Criteria Specification Sheet

Eligible Professional
Meaningful Use Table of Contents
Core and Menu Set Objectives

Eligible Professional Core Objectives		
(1)	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.	AVAILABLE
(2)	Implement drug-drug and drug-allergy interaction checks.	AVAILABLE
(3)	Maintain an up-to-date problem list of current and active diagnoses.	AVAILABLE
(4)	Generate and transmit permissible prescriptions electronically (eRx).	AVAILABLE
(5)	Maintain active medication list.	AVAILABLE
(6)	Maintain active medication allergy list.	AVAILABLE
(7)	Record all of the following demographics: (A) Preferred language. (B) Gender. (C) Race. (D) Ethnicity. (E) Date of birth.	AVAILABLE
(8)	Record and chart changes in the following vital signs: (A) Height. (B) Weight.	



Example of Clinical Summaries Measure

Eligible Professional Meaningful Use Core Measures
Measure 13 of 15
Stage 1
Date issued: April 18, 2011

Clinical Summaries	
Objective	Provide clinical summaries for patients for each office visit.
Measure	Clinical summaries provided to patients for more than 50 percent of all office visits within 3 business days.
Exclusion	Any EP who has no office visits during the EHR reporting period.

Table of Contents

- Definition of Terms
- Attestation Requirements
- Additional Information

Definition of Terms

Clinical Summary – An after-visit summary that provides a patient with relevant and actionable information and instructions containing the patient name, provider's office contact information, date and location of visit, an updated medication list, updated vitals, reason(s) for visit, procedures and other instructions based on clinical discussions that took place during the office visit, any updates to a problem list, immunizations or medications administered during visit, summary of topics covered/considered during visit, time and location of next appointment/testing if scheduled, or a recommended appointment time if not scheduled, list of other appointments and tests that the patient needs to schedule with contact information, recommended patient decision aids, laboratory and other diagnostic test orders, test/laboratory results (if received before 24 hours after visit), and symptoms.

Office Visit – Office visits include separate, billable encounters that result from evaluation and management services provided to the patient and include: (1) Concurrent care or transfer of care visits, (2) Consultant visits, or (3) Prolonged Physician Service without Direct (Face-To-Face) Patient Contact (tele-health). A consultant visit occurs when a provider is asked to render an expert opinion/service for a specific condition or problem by a referring provider.

Attestation Requirements

NUMERATOR / DENOMINATOR / EXCLUSION

- DENOMINATOR: Number of office visits by the EP during the EHR reporting period.
- NUMERATOR: Number of office visits in the denominator for which the patient is provided a clinical summary within three business days.
- EXCLUSION: EPs who have no office visits during the EHR reporting period would be excluded from this requirement. EPs must enter '0' in the Exclusion box to attest to exclusion from this requirement.

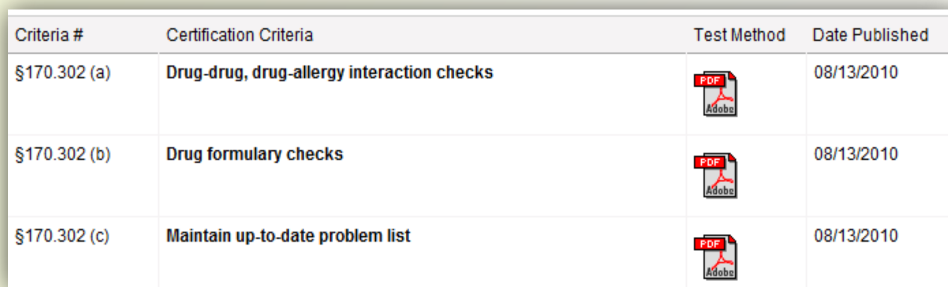
The resulting percentage (Numerator ÷ Denominator) must be more than 50 percent in order for an EP to meet this measure.

Additional Information

- The provider is permitted, but not required, to limit the measure of this objective to those patients whose records are maintained using certified EHR technology.
- The provision of the clinical summary is limited to the information contained within certified EHR technology.
- The clinical summary can be provided through a PHR, patient portal on the web site, secure e-mail, electronic media such as CD or USB fob, or printed copy. If the EP chooses an electronic media, they would be required to provide the patient a paper copy upon request.
- If an EP believes that substantial harm may arise from the disclosure of particular information, an EP may choose to withhold that particular information from the clinical summary.
- Providers should not charge patients a fee to provide this information.
- When a patient visit lasts several days and the patient is seen by multiple EPs, a single clinical summary at the end of the visit can be used to meet the meaningful use objective for "provide clinical summaries for patients after each office visit.
- The EP must include all of the items listed under "Clinical Summary" in the above "Definition of Terms" section that can be populated into the clinical summary by certified EHR technology. If the EP's certified EHR technology cannot populate all of these fields, then at a minimum the EP must provide in a clinical summary the data elements for which all EHR technology is certified for the purposes of this program (according to §170.304(h)):
  - Problem List
  - Diagnostic Test Results
  - Medication List
  - Medication Allergy List

Testing Criteria

- Testing criteria for each of these modules can be found at:
  - http://healthcare.nist.gov/use_testing/effective_requirements.html



Criteria #	Certification Criteria	Test Method	Date Published
§170.302 (a)	**Drug-drug, drug-allergy interaction checks**	PDF	08/13/2010
§170.302 (b)	**Drug formulary checks**	PDF	08/13/2010
§170.302 (c)	**Maintain up-to-date problem list**	PDF	08/13/2010

Test Procedure for §170.302.a Drug-drug, drug-allergy interaction checks
APPROVED Version 1.0 ■ August 13, 2010

Test Procedure for §170.302 (a) Drug-drug, drug-allergy interaction checks

This document describes the draft test procedure for evaluating conformance of complete EHRs or EHR modules[1] to the certification criteria defined in 45 CFR Part 170 Subpart C of the Final Rule for Health Information Technology: Initial Set of standards, Implementation Specifications, and Certification Criteria for Electronic Health Record Technology as published in the Federal Register on July 28, 2010. The document[2] is organized by test procedure and derived test requirements with traceability to the normative certification criteria as described in the Overview document located at http://healthcare.nist.gov/docs/TestProcedureOverview_v1.pdf. The test procedures may be updated to reflect on-going feedback received during the certification activities.

The HHS/Office of the National Coordinator for Health Information Technology (ONC) has defined the standards, implementation guides and certification criteria used in this test procedure. Applicability and interpretation of the standards, implementation guides and certification criteria to EHR technology is determined by ONC. Test procedures to evaluate conformance of EHR technology to ONC's requirements are defined by NIST. Testing of EHR technology is carried out by ONC-Authorized Testing and Certification Bodies (ATCBs), not NIST, as set forth in the final rule establishing the Temporary Certification Program (*Establishment of the Temporary Certification Program for Health Information Technology, 45 CFR Part 170; June 24, 2010.*)

Questions about the applicability of the standards, implementation guides or criteria should be directed to ONC at ONC.Certification@hhs.gov. Questions about the test procedures should be directed to NIST at hit-tst-fdbk@nist.gov. Note that NIST will automatically forward to ONC any questions regarding the applicability of the standards, implementation guides or criteria. Questions about functions and activities of the ATCBs should be directed to ONC at ONC.Certification@hhs.gov

- Good resource to check if you wish to know what really has been tested
  - Quality Measures – Vendors get to choose which three additional quality measures they wish to be tested on
- – Techies only need to look at this

Core:
Clinical Summaries, Part 1

- **Description (from the Final Rule):**
  - The Final Rule defines a Clinical Summary as an after-visit summary that provides a patient with relevant and actionable information and instructions containing, but not limited to:
    - The patient name
    - Provider's office contact information
    - Date and location of visit
    - An updated medication list and summary of current medications
    - Updated vitals
    - Reason(s) for visit
    - Procedures and other instructions based on clinical discussions that took place during the office visit
    - Updates to a problem list
    - Immunizations or medications administered during visit
    - Summary of topics covered/considered during visit
    - Time and location of next appointment/testing if scheduled, or a recommended appointment time if not scheduled
    - List of other appointments and testing patient needs to schedule with contact information
    - Recommended patient decision aids
    - Laboratory and other diagnostic test orders
    - Test/laboratory results (if received before 24 hours after visit)
    - Symptoms

Testing Criteria for a Clinical Summary*

Test Procedure for §170.304.h Clinical Summaries
APPROVED Version 1.1 ■ September 24, 2010

Test Procedure for §170.304 (h) Clinical Summaries

This document describes the test procedure for evaluating conformance of complete EHRs or EHR modules[1] to the certification criteria defined in 45 CFR Part 170 Subpart C of the Final Rule for Health Information Technology: Initial Set of standards, Implementation Specifications, and Certification Criteria for Electronic Health Record Technology as published in the Federal Register on July 28, 2010. The document[2] is organized by test procedure and derived test requirements with traceability to the normative certification criteria as described in the Overview document located at http://healthcare.nist.gov/docs/TestProcedureOverview_v1.pdf. The test procedures may be updated to reflect on-going feedback received during the certification activities.

Reading down several pages:

TE170.304.h – 1.04: Using the Vendor-supplied test data and/or NIST-supplied test data/examples and the EHR function(s) identified by the Vendor, the Tester shall create a clinical summary for an office visit, including

- Diagnostic test results
- Problem list
- Medication list
- Medication allergy list

TE170.304.h – 1.05: Using the NIST-supplied Inspection Test Guide, the Tester shall verify that the clinical summary has been created correctly and without omission

* http://healthcare.nist.gov/use_testing/effective_requirements.html

CMS Clinical Summary FAQ

- From the CMS website:
  - "...The EP must include all of the above that can be populated into the clinical summary by certified EHR technology. If the EP's certified EHR technology cannot populate all of the above fields, then at a minimum the EP must provide in a clinical summary the data elements for which all EHR technology is certified for the purposes of this program (according to §170.304(h)):
    - Problem List
    - Diagnostic Test Results
    - Medication List
    - Medication Allergy List"

http://questions.cms.hhs.gov/app/answers/detail/a_id/10558/kw/10558/

Small Groups

Outline

- Background to the Final Rule
- Financial Incentives for Professionals
- Knowing if Your EHR is Certified
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- **Registration and Attestation**
- Quality Measures
- Proposed Stage II Criteria
- Capturing the Information
- Closure

Incentive Program Registration & Attestation System

- Central registration point for both Medicaid and Medicare EHR incentives
- Ensure no duplication of payments between Medicare and Medicaid and between states
- Allows Medicare to meet its mandate for online posting requirements
- Tracks EHR incentives nationally
- Ensures accurate and timely payments

Registration: Eligible Professionals

- All eligible professionals must have:
  - NPI number
  - National Plan and Provider Enumeration System (NPPES) web user account.
- EPs will be directed to the NPPES site from the registration site if they do not have an NPI or NPPES number
- EPs use their NPPES userID and password to log in to the registration site.
- The Medicaid EHR program is administered at the state level
  - Professionals first must register in the national database as with Medicare professionals
  - Medicaid professionals must also register and attest at the state web site

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Registration: On Behalf of an Eligible Professional

- Authorized user can register for one or more EPs
  - Must have CMS Identify and Access Management (I&A) User ID and password
- The authorized user creates an Organization I&A web user account if none exists
- Once the account is created, that person uses the organization's I&A web user login to submit an Access Request for each EP for whom they wish to register and attest
  - NPI data required for each EP
- The EPs account shows a pending Access Request which must be approved by:
  - The professional or
  - An individual acting on behalf of the Organization who has the EP's NPPES login credentials (UserID and password)

Registering on Behalf of a Professional

Organization (Clinic or Hospital)

Clinic / Clinic Manager can now register & attest on behalf of Eligible Providers!

Request Identity & Access account

CMS I&A system

I&A account created

Request access for each professional via I&A system

Professional approve access
(clinic can do this if providers provide NPPES/ NPI login to clinic manager)

What You Need to Begin

- Agreement and understanding from your EPs that a third party (you) will be registering them in the EHR Incentive program
  - Some organizations use contract language to discuss; others discuss or send a memo
- NPIs for all EPs
- An Organization NPPES/NPI Username & Password (a.k.a. login credentials)
  - If not, you need to be create one or “find” it
- NPPES/NPI login credentials needed for each EP – whether the EP creates this, or the organization creates it
- Access (proxy) to your EP’s NPPES/NPI login credentials
  - If not, contact CMS helpdesk support for both EPs and Organizations to request this information. New credentials can be created if none exist.

Registration: Eligible Professionals

- Login to the Registration and Attestation System
- Select Program (Medicare or Medicaid)
- If Medicaid, select Medicaid state
- Enter Eligible Professional Type
- State you have a certified EHR
  - The Certified EHR Number is not required at point of registration
  - Required for attestation
- Pick a SSN or TIN for incentive receipt
- Complete the registration
- You will receive notification when your registration is accepted

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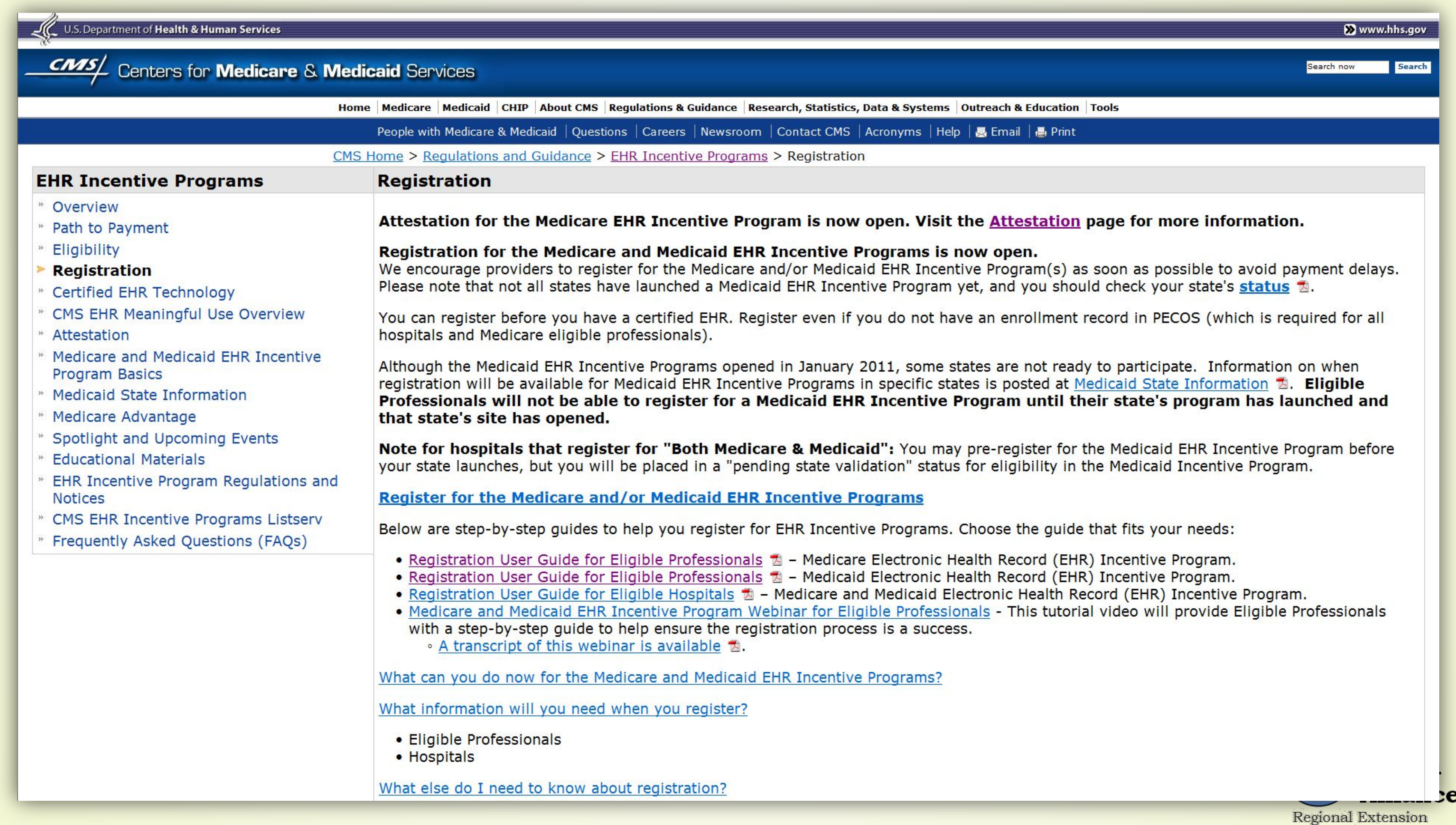
After Registration and Before Attestation

- You may continue incomplete registration
- Modify existing registration
- Switch incentive program (Medicare Medicaid) without penalty
- Switch Medicaid state
- Cancel participation

Registration Instructions

http://www.cms.gov/EHRIncentivePrograms/20_RegistrationandAttestation.asp



Regional Extension Assistance Center for HIT

Medicare Registration Guide for EPs

REGISTRATION
USER GUIDE
For Eligible Professionals

Medicare Electronic Health Record
(EHR) Incentive Program

JULY 2011
(07.27.11 ver6)

REGISTRATION USER GUIDE
FOR MEDICARE ELIGIBLE PROFESSIONALS

https://ehrincentives.cms.gov

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Disclaimer

The Centers for Medicare & Medicaid Services (CMS) is providing this material as an informational reference for physicians and non-physician practitioners-providers.

Although every reasonable effort has been made to assure the accuracy of the information within these pages at the time of posting, the Medicare program is constantly changing, and it is the responsibility of each physician, non-physician practitioner, supplier or provider to remain abreast of the Medicare program requirements.

Medicare regulations can be found on the CMS Web site at ***http://www.cms.gov***

Medicare EHR Incentive Program User Guide – Page 2

Medicaid Registration Guide for EPs

REGISTRATION USER GUIDE
For Eligible Professionals

Medicaid Electronic Health Record (EHR) Incentive Program

DECEMBER 2010
(01.20.11 ver3)

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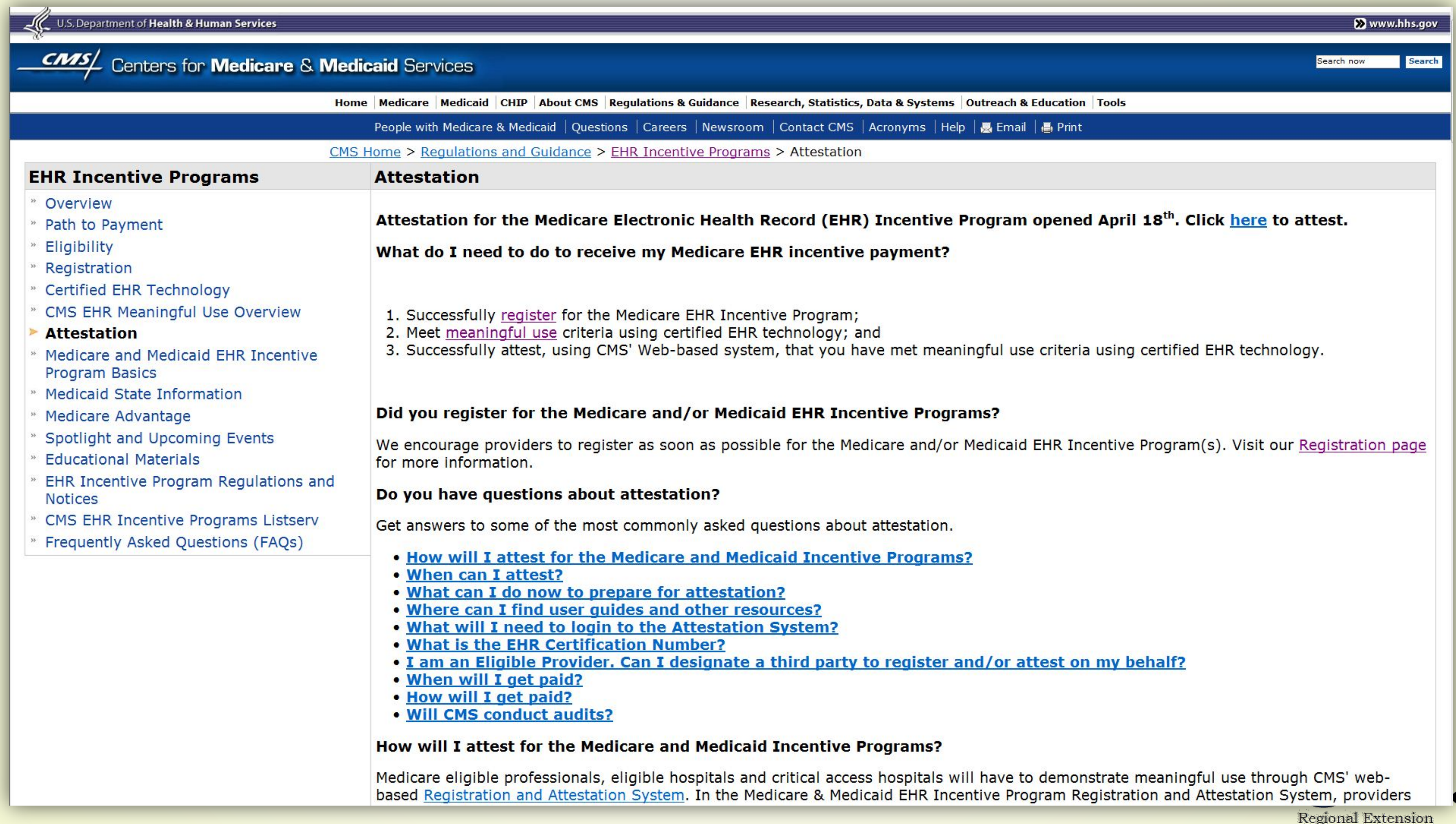
Attestation

- Log in the Registration / Attestation site
- Include you EHR Certification number
- Walk through the core criteria
- Select and report on the menu criteria
- Report numerator and denominators for quality measures
- Select and report on the three additional quality measures

Attestation Instructions

http://www.cms.gov/EHRIncentivePrograms/32_Attestation.asp



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Attestation Worksheet

Eligible Professional (EP) Attestation Worksheet for the Medicare Electronic Health Record (EHR) Incentive Program

The EP Attestation Worksheet allows EPs to log their meaningful use measures on this page to use as a reference when attesting for the Medicare EHR Incentive Program in the CMS system.

Numerator, denominator, and exclusion information for clinical quality measures (CQMs) must be reported directly from information generated by certified EHR technology and are not included in this worksheet. However, information for the remaining meaningful use core and menu set measures does not necessarily have to be entered directly from information generated by certified EHR technology. For each objective with a percentage-based measure, certified EHR technology must include the capability to electronically record the numerator and denominator and generate a report including the numerator, denominator, and resulting percentage for these measures. However, EPs may use additional data to calculate numerators and denominators and to generate reports on all measures of the core and menu set meaningful use objectives except CQMs. In order to provide complete and accurate information for certain of these measures, EPs may also have to include information from paper-based patient records or from records maintained in uncertified EHR technology.

EPs can enter their meaningful use criteria in the blue boxes. Each measure's objective is included to help EPs enter the correct criteria. Certain measures do not require a numerator and denominator, but rather a yes/no answer, and are marked as such. Measures with exclusions have the exclusion description listed in the measure information section.

Note: Claiming an exclusion for a specific measure qualifies as submission of that measure. If an EP claims an exclusion for which they qualify, indicate this in the Attestation System by clicking "yes" under the exclusion part of the measure question.

EPs must meet report on the following:

1. All 15 of the core measures
   Note: One of the required core measures is that EPs report clinical quality measures (CQMs)
2. 5 out of 10 of the menu measures; at least 1 public health measure must be selected
3. A sum total of up to 9 CQMs; 3 core, up to 3 alternate core, and 3 additional CQMs. If an EP reports a denominator of 0 for any of the 3 core measures, the EP must record for an alternate core CQM to supplement the core measure. Therefore, an EP may report a minimum of 6 and a maximum of 9 CQMs depending on the resulting values in the denominators for the core measures as reported from their certified EHR.

Reporting Period: For an EP the reporting period must be at least 90 consecutive days within calendar year 2011 (January 1, 2011, through December 31, 2011).

1

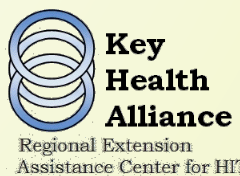
Meaningful Use Core Measures- EPs must fill out all 15 core measures

#	Measure Information	Measure Values
1	**Objective:** Use computerized provider order entry (CPOE) for medication orders directly entered by a licensed healthcare professional who can enter orders into the medical record per state, local and professional guidelines **Measure:** More than 30 percent of all unique patients with at least one medication in their medication list seen by the EP have at least one medication order entered using CPOE **Exclusion:** Any EP who writes fewer than 100 prescriptions during the EHR reporting period would be excluded from this requirement	
	Does this exclusion apply to you?	Yes ☐ No ☐
	Numerator: The number of patients in the denominator that have at least one medication order entered using CPOE	
	Denominator: Number of unique patients with at least one medication in their medication list seen by the EP during the EHR reporting period	
2	**Objective:** Implement drug-drug and drug-allergy interaction checks **Measure:** The EP has enabled this functionality for the entire EHR reporting period Note: This measure only requires a yes/no answer	
	Numerator: N/A	☐ YES ☐ NO
	Denominator: N/A	
3	**Objective:** Maintain an up-to-date problem list of current and active diagnoses **Measure:** More than 80 percent of all unique patients seen by the EP have at least one entry or an indication that no problems are known for the patient recorded as structured data	
	Numerator: Number of patients in the denominator who have at least one entry or an indication that no problems are known for the patient recorded as structured data in their problem list	
	Denominator: Number of unique patients seen by the EP during the EHR reporting period	
4	**Objective:** Generate and transmit permissible prescriptions electronically (eRx) **Measure:** More than 40 percent of all permissible prescriptions written by the EP are transmitted electronically using certified EHR technology **Exclusion:** Any EP who writes fewer than 100 prescriptions during the EHR reporting period would be excluded from this requirement	
	Does this exclusion apply to you?	Yes ☐ No ☐
	Numerator: Number of prescriptions in the denominator generated and transmitted electronically	
	Denominator: Number of prescriptions written for drugs requiring a prescription in order to be dispensed other than controlled substances during the EHR reporting period	

2

Registration and Attestation Instructions

- Registration instructions:
  - http://www.cms.gov/EHRIncentivePrograms/20_RegistrationandAttestation.asp
- Registration video (with older attestation info):
  - http://www.youtube.com/watch?v=kL-d7zj44Fs
- Attestation Instructions:
  - http://www.cms.gov/EHRIncentivePrograms/32_Attestation.asp
- New attestation video:
  - http://www.youtube.com/watch?v=B9ftFgLS1fI&feature=relmfu



Important Dates

- October 3, 2011
  - Last day for eligible professionals to begin their 90-day reporting period for calendar year 2011 for the Medicare EHR Incentive Program.
- December 31, 2011
  - Reporting year ends for eligible professionals.
- January 1, 2012
  - Calendar year 2012 reporting period starts for eligible professionals
- February 29, 2012
  - Last day for eligible professionals to register and attest to receive an Incentive Payment for calendar year (CY) 2011
- March 31, 2012
  - First day that an EP can attest to a 90-day reporting period for calendar year 2012 (Applies only if this is their first year to attest to meaningful use)

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Register Now

- Professionals
  - May register for the Medicare program and attest to meaningful use now
  - North Dakota providers may also register for the Medicaid program
  - Recommend registering early to be sure all information is available and correct
- State readiness:
  - http://www.cms.gov/apps/files/medicaid-HIT-sites/

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Outline

- Background to the Final Rule
- Financial Incentives for Professionals
- Knowing if Your EHR is Certified
- Elements of Meaningful Use
- Registration and Attestation
- **Quality Measures**
- Proposed Stage II Criteria
- Capturing the Information
- Closure

Quality Measures

- Relate to healthcare quality aims such as effective, safe, efficient, patient-centered, equitable, and timely care.
- Includes measures of processes, experience, and/or outcomes of patient care, observations or treatment
  - Draw primarily from PQRI and NQF endorsed measures
- EPs would be required to submit clinical data on 2 measure groups:
  - A core set of 3 measures (or alternates)
  - 3 additional measures selected from among 38 others

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Reporting of Clinical Quality Measures

- Quality reporting will be done by attestation of summary data to CMS in 2011
- For the 2012 payment year, professionals will be required to submit these measures
  - To CMS electronically if choosing Medicare
  - To the states if choosing Medicaid
- All measures have specifications for electronic reporting
- Reporting limited to patients in the EHR
- Patient information must be submitted regardless of payer

Core Quality Measures for EPs

Measure Number	Clinical Quality Measure Title
NQF 0013	Blood pressure measurement
NQF 0028	Tobacco use assessment and intervention
NQF 0421 PQRI 128	Adult Weight Screening and Follow-up
Alternate Core Measures	
NQF 0024	Weight Assessment and Counseling for Children and Adolescents
NQF 0041 PQRI 110	Influenza Immunization for Patients ≥ 50 Years Old
NQF 0038	Childhood Immunization Status

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Core: NQF 0013: Hypertension: BP Measurement

- **Initial Patient Population**
  - Age >= 18 years;
  - Active Diagnosis of hypertension
  - AND: >=2 count(s) of:
    - outpatient encounter
    - nursing facility encounter
- **Denominator**
  - All patients in the initial patient population
- **Numerator**
  - Physical exam finding: systolic blood pressure
  - AND: Physical exam finding: diastolic blood pressure
- **Exclusions**
  - None

Core: NQF 0028a: Tobacco Use Assessment

- **Initial Patient Population**
  - Age >= 18 years;
  - AND:
    - >=2 count(s) of:
      - Encounter office visit, health and behavior assessment, occupational therapy or psychiatric/psychologic
    - OR:
      - >=1 count(s) of:
        - preventive services encounter 18 and older, medical, counseling or other
- **Denominator**
  - All patients in the initial patient population;
- **Numerator**
  - Patient characteristic: tobacco user before or simultaneously to the encounter <=24 months;
  - OR: Patient characteristic: tobacco non-user before or simultaneously to the encounter <=24 months;
- **Exclusions**
  - None;

Core: NQF 0028b: Tobacco Use Assessment

- **Initial Patient Population**
  - Age >= 18 years;
  - AND:
    - >=2 count(s) of:
      - Encounter office visit, health and behavior assessment, occupational therapy or psychiatric/psychologic
    - OR:
      - >=1 count(s) of:
        - preventive services encounter 18 and older, medical, counseling or other
- **Denominator**
  - All patients in the initial patient population;
  - AND: Patient characteristic: tobacco user <= 24 months;
- **Numerator**
  - Procedure: tobacco use cessation counseling <= 24 months;
  - OR: Ordered or using smoking cessation agents before or simultaneously to the encounter <= 24 months;
- **Exclusion**
  - None;

Core: NQF 0421 (Population Criteria 1) Adult Weight Screening and Follow-Up

- **Initial Patient Population**
  - Age >= 65 years;
- **Denominator**
  - All patients in the initial patient population;
  - AND: >=1 count(s) of outpatient encounter;
- **Numerator 1**
  - Physical exam finding: BMI >=22 kg/m² and <30 kg/m², occurring <=6 months before or simultaneously to the outpatient encounter;
  - OR: Physical Exam Finding: outside the above parameters occurring <=6 months before or simultaneously to the outpatient encounter;
    - AND:
      - OR: Care goal: follow-up plan BMI management;
      - OR: Communication provider to provider: dietary consultation order;
- **Exclusions**
  - Patient characteristic: Terminal illness <=6 months before or simultaneously to outpatient encounter;
  - OR: Diagnosis active: Pregnancy;
  - OR: Physical exam not done for patient, medical or system reason

Core: NQF 0421 (Population Criteria 2) Adult Weight Screening and Follow-Up

- **Initial Patient Population**
  - Age >= 18 years AND <= 64 years;
- **Denominator**
  - All patients in the initial patient population;
  - AND: >=1 count(s) of outpatient encounter;
- **Numerator 2**
  - Physical exam finding: BMI >=18.5 kg/m² and <25 kg/m², occurring <=6 months before or simultaneously to the outpatient encounter;
  - OR: Physical Exam Finding: outside the above parameters occurring <=6 months before or simultaneously to the outpatient encounter;
    - AND:
      - OR: Care goal: follow-up plan BMI management;
      - OR: Communication provider to provider: dietary consultation order;
- **Exclusions**
  - Patient characteristic: Terminal illness <=6 months before or simultaneously to outpatient encounter;
  - OR: Diagnosis active: Pregnancy;
  - OR: Physical exam not done for patient, medical or system reason

Alt Core: NQF 0024: Weight Assessment and Counseling for Children and Adolescents

- **Initial Patient Population 1**
  - Age >=2 and <=16 years to expect screening for patients within one year after reaching 2 years until 17 years;
- **Initial Patient Population 2**
  - Age >=2 and <=10 years to expect screening for patients within one year after reaching 2 years until 11 years;
- **Initial Patient Population 3**
  - Age >=11 and <=16 years to expect screening for patients within one year after reaching 12 years until 17 years;
- **Denominator**
  - outpatient encounter w/PCP & obgyn;
  - AND NOT: Diagnosis active: pregnancy;
  - AND NOT: pregnancy encounter;
- **Numerator 1**
  - Physical exam finding: BMI percentile;
- **Numerator 2**
  - Communication to patient: counseling for nutrition;
- **Numerator 3**
  - Communication to patient: counseling for physical activity
- **Exclusions**
  - None;
- **Stratified**
  - According to age with three numerators each

Alt Core: NQF-0041: Influenza Immunization Patients > 50 Years

- **Initial Patient Population**
  - Age >= 50 years:
  - AND:
    - OR: >=2 count(s) of outpatient encounter;
    - OR: >=1 count(s) of:
      - OR: preventive medicine encounter 40 and older;
      - OR: preventive medicine group counseling;
- **Denominator**
  - All patients in the initial population;
  - AND: an encounter after the first of September before the measurement period;
  - AND: an encounter before March in the measurement period
- **Numerator**
  - AND: Medication administered: influenza vaccine;
- **Exclusions**
  - Influenza immunization contraindication, declined, patient reason or medical reason;

Alt Core: NQF 0038: Childhood Immunization Status

- **Initial Patient Population**
  - Age >=1 year and <2 years to capture all patients who will reach 2 years during the measurement period;
- **Denominator**
  - All patients in the initial patient population;
  - AND: outpatient encounter w/PCP & obgyn;
- **All Numerators**
  - Measuring appropriate immunization status
- **Numerator 1**
  - DTaP immunizations before 2 years of age
- **Numerator 2**
  - IPV before 2 years of age
- **Numerator 3**
  - MMR before 2 years of age
- **Numerator 4**
  - HiB between 42 days and 2 years
- **Numerator 5**
  - HepB before 2
- **Numerator 6**
  - VSV before 2
- **Numerator 7**
  - Pneumococcal bet 42 days and 2 years
- **Numerator 8**
  - HepA before 2 years
- **Numerator 9**
  - Rotavirus before 2 years
- **Numerator 10**
  - Influenza after 180 days and before 2 years
- **Numerator 11**
  - DTaP, IPV, MMR, VSV, HepB
- **Numerator 12**
  - DTaP, IPV, MMR, VSV, HepB, Pneumococcal

Optional Quality Measures – Diabetes

- Hemoglobin A1c Poor Control
- Low Density Lipoprotein (LDL) Management and Control
- Blood Pressure Management
- Retinopathy: Documentation of Presence or Absence of Macular Edema and Level of Severity of Retinopathy
- Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care
- Eye Exam
- Urine Screening
- Foot Exam
- Hemoglobin A1c Control (<8.0%)

Optional Quality Measures – Cardiovascular Disease

- Coronary Artery Disease (CAD):
  - Beta-Blocker Therapy for CAD Patients with Prior Myocardial Infarction (MI)
  - Oral Antiplatelet Therapy Prescribed for Patients with CAD
  - Drug Therapy for Lowering LDL-Cholesterol
- Heart Failure (HF):
  - Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD)
  - ACE Inhibitor or ARB Therapy for Left Ventricular Systolic Dysfunction (LVSD)
  - Warfarin Therapy Patients with Atrial Fibrillation
- Ischemic Vascular Disease (IVD)
  - Blood Pressure Management
  - Use of Aspirin or Another Antithrombotic
  - Complete Lipid Panel and LDL Control

Optional Quality Measures – Prevention

- Influenza Immunization for Patients ≥ 50 Years Old
- Pneumonia Vaccination Status for Older Adults
- Breast Cancer Screening
- Colorectal Cancer Screening
- Cervical Cancer Screening
- Chlamydia Screening for Women
- Prenatal Care:
  - Screening for Human Immunodeficiency Virus (HIV)
  - Prenatal Care: Anti-D Immune Globulin
- Weight Assessment and Counseling for Children and Adolescents
- Childhood Immunization Status

Optional Quality Measures – Other

- Appropriate Use:
  - Appropriate Testing for Children with Pharyngitis
  - Prostate Cancer: Avoidance of Overuse of Bone Scan for Staging Low Risk Prostate Cancer Patients
  - Low Back Pain: Use of Imaging Studies
- Asthma:
  - Pharmacologic Therapy
  - Asthma Assessment
  - Use of Appropriate Medications for Asthma

Optional Quality Measures – Other

- Smoking and Tobacco Use:
  - Advising Smokers and Tobacco Users to Quit
  - Discussing Cessation Medications and Strategies
- Alcohol and Other Drug Dependence Treatment:
  - Initiation
  - Engagement
- Anti-depressant medication management:
  - Effective Acute Phase Treatment
  - Effective Continuation Phase Treatment
- Oncology:
  - Hormonal Therapy for Stage IC-IIIC Estrogen Receptor/ Progesterone Receptor (ER/PR) Positive Breast Cancer
  - Chemotherapy for Stage III Colon Cancer Patients
- Primary Open Angle Glaucoma (POAG): Optic Nerve Evaluation
- Controlling High Blood Pressure

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Professional QM Specifications

http://www.cms.gov/QualityMeasures/03_ElectronicSpecifications.asp

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CMS Home > Medicare > Quality Measures > Electronic Specifications

Quality Measures

- Overview
- **Electronic Specifications**

Electronic Specifications

In order to report quality measures from an electronic health record (EHR), electronic specifications must be developed that include the data elements, logic and definitions for that measure in a

Downloads

Guide for Reading the EHR Incentive Program EP Measures [PDF 230 KB]

EP Supplemental Measures Specification [ZIP 5 MB]

EP CQM Supplemental LOG [PDF 148 KB]

Emergency Department Throughput Measures Stratification [PDF 47.5 KB]

Eligible Professional Clinical Quality Measures [PDF 52 KB]

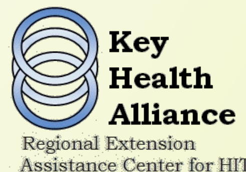
EP Measure Specifications [ZIP 6.35 MB]

Related Links Inside CMS

PQRI

Related Links Outside CMS

HITSP Technical Note



Professional Specification Guide

Guide for Reading the EHR Incentive Program EP Measures

October 2010

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Measure Specification: “Human Readable”

Prenatal Care: Anti-D Immune Globulin (NQF 0014)

EMeasure Name	Prenatal Care: Anti-D	EMeasure Id	Pending

	The USPSTF recommends the repeated Rh (D) antibody testing for all unsensitized Rh (D)-negative women at 24-28 weeks gestation, unless the biological father is known to be Rh (D)-negative (USPSTF) (B Recommendation).

- Exclusions =
  - OR:
    - AND:
      - OR: "Medication administered not done: Patient reason" for "Anti-D Immune Globulin RxNorm Code List"

- “Laboratory test result: Rh status baby” using the “encounter Rh status baby code list” before or simultaneously to “Procedure performed: delivery live births-procedure”;
- “Diagnosis: multigravida” using the “multigravida code list” during the “measurement period”;
- “Encounter: prenatal visit” using the “prenatal visit code list” after “Patient characteristic: estimated date of conception”;

- Numerator =
  - “Patient characteristic: estimated date of conception” using the “estimated date of conception code list” before “Procedure performed: delivery live births-procedure”;
  - “Medication administered: anti-D immune globulin” using the “anti-D immune globulin code list grouping”;
- Exclusions =
  - “Medication not done: patient reason” using the “patient reason code list” for “anti-D immune globulin”;
  - “Medication not done: medical reason” using the “medical reason code list” for “anti-D immune globulin”;
  - “Medication not done: system reason” using the “system reason code list” for “anti-D immune globulin”;
  - “Medication not done: anti-D immune globulin declined” using the “anti-D immune globulin declined code list” for “Medication administered: anti-D immune globulin”;

Summary Calculation

Calculation is generic to all measures:

- Calculate the final denominator by adding all that meet denominator criteria.
- Subtract from the final denominator all that do not meet numerator criteria yet also meet exclusion criteria. Note some measures do not have exclusion criteria.
- The performance calculation is the number meeting numerator criteria divided by the final denominator.
- For measures with multiple patient populations, repeat this process for each patient population and report each result separately.
- For measures with multiple numerators, calculate each numerator separately within each population using the paired exclusion.

Measure set	CLINICAL QUALITY MEASURE SET 2011-2012

Professional Retooled Measure

NQF_id	measure_name	QDS_id	standard_concept	standard_category	QDS_data_type	standard_concept_id	standard_taxonomy	standard_taxonomy_version	standard_code_list	QDS_datatype_specific_attributes
0014	Prenatal Care: Anti-D Immune Globulin	A_215	Delivery Live Births-Diagnosis	Diagnosis / Condition / Problem	diagnosis active	A_c87	ICD-9-CM	2009	641.01, 641.11, 641.21, 641.31, 641.81, 641.91, 642.01, 642.02, 642.11, 642.12, 642.21, 642.22, 642.31, 642.32, 642.41, 642.42, 642.51, 642.52, 642.61, 642.62, 642.71, 642.72, 642.91, 642.92, 643.21, 643.81, 644.21, 645.11, 645.21, 646.01, 646.11, 646.12, 646.21, 646.22, 646.31, 646.41, 646.42, 646.71, 646.91, 647.01, 647.02, 647.11, 647.12, 647.21, 647.22, 647.31, 647.32, 647.41, 647.42, 647.51, 647.52, 647.61, 647.62, 647.81, 647.82, 647.91, 647.92, 648.01, 648.02, 648.11, 648.12, 648.21, 648.22, 648.31, 648.32, 648.41, 648.42, 648.51, 648.52, 648.61, 648.62, 648.71, 648.72, 648.81, 648.82, 648.91, 648.92, 649.01, 649.02, 649.11, 649.12, 649.21, 649.22, 649.31, 649.32, 649.41, 649.42, 649.51, 649.61, 649.62, 65.621, 651.01, 651.11, 651.21, 651.31, 651.41, 651.51, 651.61, 651.71, 651.81, 651.91, 652.01, 652.11, 652.21, 652.31, 652.41, 652.51, 652.61, 652.71, 652.81, 652.91, 653.01, 653.11, 653.21, 653.31, 653.41, 653.51, 653.61, 653.71, 653.81, 653.91, 654.01, 654.02, 654.11, 654.12, 654.31, 654.32, 654.41, 654.42, 654.51, 654.52, 654.61, 654.62, 654.71, 654.72, 654.81, 654.82, 654.91, 654.92, 655.01, 655.11, 655.21, 655.31, 655.41, 655.51, 655.61, 655.71, 655.81, 655.91, 656.01, 656.11, 656.31, 656.51, 656.61, 656.71, 656.81, 656.91, 657.01, 658.01, 658.11, 658.21, 658.31, 658.41, 658.81, 658.91, 659.01, 659.11, 659.21, 659.31, 659.41, 659.51, 659.61, 659.71, 659.81, 659.91, 660.01, 660.11, 660.21, 660.31, 660.41, 660.51, 660.61, 660.71, 660.81, 660.91, 661.01, 661.11, 661.21, 661.31, 661.41, 661.91, 662.01, 662.11, 662.21, 662.31, 663.01, 663.11, 663.21, 663.31, 663.41, 663.51, 663.61, 663.81, 663.91, 664.01, 664.11, 664.21, 664.31, 664.41, 664.51, 664.61, 664.81, 664.91, 665.01, 665.11, 665.31, 665.41, 665.51, 665.61, 665.71, 665.72, 665.81, 665.91, 665.92, 666.02, 666.12, 666.22, 666.32, 667.02, 667.12, 668.01, 668.02, 668.11, 668.12, 668.21, 668.22, 668.81, 668.82, 668.91, 668.92, 669.01, 669.02, 669.11, 669.12, 669.21, 669.22, 669.32, 669.41, 669.42, 669.51, 669.61, 669.71, 669.81, 669.82, 669.91, 669.92	DATETIME

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Small Groups

Outline

- Background to the Final Rule
- Financial Incentives for Professionals
- Knowing if Your EHR is Certified
- Elements of Meaningful Use
- Registration and Attestation
- Quality Measures
- **Proposed Stage 2 Criteria**
- Capturing the Information
- Closure

Core Criteria (page 1 of 3)

Objective	Stage 1	Policy Committee Proposed Stage 2
CPOE[3] (Lic HC Prof)	>30% of patients on any meds with ≥ one CPOE med order (n/d EHR)[1]	>60% meds and labs and 1 radiology order (if any)
Drug (D-A, D-D) Interactions	Turned on (y/n)	No change
ePrescribe[3]	>40% of permissible scripts (n/d EHR)[1]	>50%
Demographics	>50% of patients seen: language, gender, race, ethnicity, DOB (n/d all)[2]	>80%
Problem List	>80% of patients seen at least one or "none" *as structured data* (n/d all)[2]	No change
Med List		
Med Allergies		

1. (n/d EHR): Numerator divided by denominator of all unique patients seen during the measurement period whose records are maintained in a certified EHR
2. (n/d all): Numerator divided by denominator of all unique patients seen during the measurement period
3. CPOE and ePrescribe excluded if < 100 scripts written

Core Criteria (page 2 of 3)

Objective	Stage 1	Proposed Stage 2
Vitals[2]	>50% of patients ≥ 2yo seen: height, weight, BP, BMI, & for age 2-20: growth charts w/BMI (n/d EHR)[1]	>80% and increased peds from ≥ 2 years to ≥ 3 years of age
Smoking	>50% of patients ≥ 13yo seen, record status *as structured data* (n/d EHR)[1]	>80%
Decision Support	1 CDS rule relevant to the specialty specific quality metric *with the ability to track compliance* (y/n)	Change unclear
Quality Reporting	Report ambulatory quality measures to CMS or states (y/n) 2011: Attest numerator/denominator 2012: Electronic submission	Electronic submission

1. (n/d EHR): Numerator divided by denominator of all unique patients seen during the measurement period whose records are maintained in a certified EHR
2. Exclusion if pts ht, wt, & BP have no relevance to scope of practice

Core Criteria (page 3 of 3)

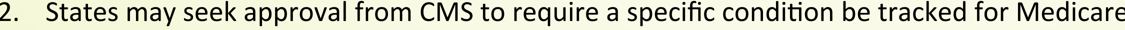
Objective	Stage 1	Proposed Stage 2
eHealth summary	>50% of patients who request it (incl: test results, prob list, med list, med allergies) w/i 3 business days (n/d EHR)[1]	Moved into another criteria (See eAccess)
Clinical summaries	>50% of office visits, a patient gets a visit summary within 3 business days (n/d EHR)[1]	50% of visits w/i 24 hrs, Labs w/I 4 days of result Electronic access counts
Exchange with providers[2]	Capability of electronic exchange of key information (Ex: prob list, med list, allergies, test results[3]). One test per measurement period (y/n)	Substituted
Protect Patient Personal Health Information	Conduct or review a security risk analysis per 45 CFR 164.308 (a)(1) and correct deficiencies (y/n)	No change

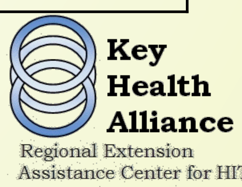
1. (n/d EHR): Numerator divided by denominator of all unique patients seen during the measurement period whose records are maintained in a certified EHR
2. Clinical information must be sent between different legal entities with distinct certified EHR technology or other system that can accept the information and not between organizations that share certified EHR technology
3. "Diagnostic test results " are all data needed to diagnose and treat disease, such as blood tests, microbiology, urinalysis, pathology tests, radiology, cardiac imaging, nuclear medicine tests, and pulmonary function tests.

Menu Criteria (page 1 of 2)

Objective	Stage 1	Proposed Stage 2
Formularies	Implement drug formulary checks with at least one internal or external formulary (y/n)	May use a generic sub formulary Moved to Core
Lab Results	>40% of labs with numeric or +/- result in chart as structured data (n/d EHR)[1]	Moved to Core
Patient Lists[2]	Generate at least one pt lists based on a specific condition (y/n)	Multiple lists Moved to Core
Reminders	>20% of pts ≥ 65 or ≤ 5yo sent reminders for follow up care (n/d EHR)[1]	10% of ALL patients – not for existing appts. Moved to Core
eAccess	>10% patients seen with electronic access to lab results, prob lists, med list, med allergies w/i 4 business days of it being updated in the EHR (n/d all)[1]	10% of patients access to longitudinal record w/i 24 hrs, or w/I 4 days after available to EP. Moved to Core
Patient Ed	>10% patients seen provided with ed resources identified with the EHR (n/d all)[1]	Removed "If appropriate" Moved to Core

1. (n/d EHR): Numerator divided by denominator of all unique patients seen during the measurement period whose records are maintained in a certified EHR
2. States may seek approval from CMS to require a specific condition be tracked for Medicare





Menu Criteria (page 2 of 2)

Objective	Stage 1	Proposed Stage 2
Medication reconciliation	>50% of transitions of care or a relevant encounter[2] (n/d EHR)	Moved to Core
Summary care record	>50% of referrals and transitions of care (n/d EHR)	>25 electronic transactions Moved to Core
Immunization Records	≥ 1 test of submission to state immunization registry (unless no registries are capable) with continued submission if successful (y/n)	Success required Moved to Core
Syndromic Surveillance	≥ 1 test of submission to public health (unless no ph agency is capable) with continued submission if successful (y/n)	CMS to consider

Proposed New Stage 2 Criteria

Objective	Ambulatory Measure
Advanced Directives	>25 unique patients have recorded whether an advance directive exists (with date and timestamp of recording) and access to a copy of the directive itself if it exists
Progress Notes	30% of EP visits have at least one electronic EP note. Scanned notes do not qualify
Secure Messaging	Patients are offered secure messaging online and at least 25 patients have sent secure messages online
Communication Preference	Patient preferences for communication medium recorded for 20% of patients
Care Team	List of care team members (including PCP, if available) available for 10% of patients via electronic exchange; (May be unstructured data for stage 2)
Cancer Reporting	CMS to Consider: Submit reportable cancer conditions (attest to at least one) in accordance with applicable law and practice

Outline

- Background to the Final Rule
- Financial Incentives for Professionals
- Knowing if Your EHR is Certified
- Elements of Meaningful Use
- Registration and Attestation
- Quality Measures
- Proposed Stage II Criteria
- **Capturing the Information**
- Closure

The Patient Experience

- Margaret is a 48-year-old diabetic patient, known to the clinic, believed to be under good control, calls your office to refill her medications. Due to your success with open access scheduling, the front desk was able to get her in the next day. She has been staying with her cousin in San Diego for 6 months and is now home. Though you have been live on the EHR for several months, this visit was unexpected and so you have not loaded her information from the paper chart. Take the criteria and measures listed on the next slides and identify where on the patient experience timeline (starting with when she makes the appointment to when she leaves the clinic to go home) where each of the measures can be collected or met during the visit. Hint: each criteria and measure can appear in several different places on the time line and can be either collected or verified by multiple staff.

Patient makes Appointment → Arrives at front desk → Waits in the reception area → Roomed by medical assistant → Examined by physician → Leaves the office → Patient at home

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The Criteria

- CPOE
- ePrescribe
- Demographics
- Problem List
- Med List
- Med Allergies
- Vitals
- Smoking
- Visit summaries

- Decision Support
- Quality Reporting
- eHealth summary
- Drug (D-A, D-D) Interactions
- Exchange with providers
- Protect Patient Personal Health Information

- Reminders
- eResults
- Patient Ed
- Medication reconciliation
- Summary care record for referrals
- Immunization Records

- Formularies
- Lab Results
- Patient Lists
- Syndromic Surveillance

The Measures

- Blood pressure measurement
- Tobacco use assessment and intervention
- Adult Weight Screening and Follow-up

- Diabetes Mellitus: Hemoglobin A1c Poor Control in Diabetes Mellitus
- Diabetes: Low Density Lipoprotein (LDL) Management and Control
- Diabetes: Blood Pressure Management
- Diabetes: Eye Exam
- Diabetes: Urine Screening
- Diabetes: Foot Exam
- Diabetes: Hemoglobin A1c Control (<8.0%)

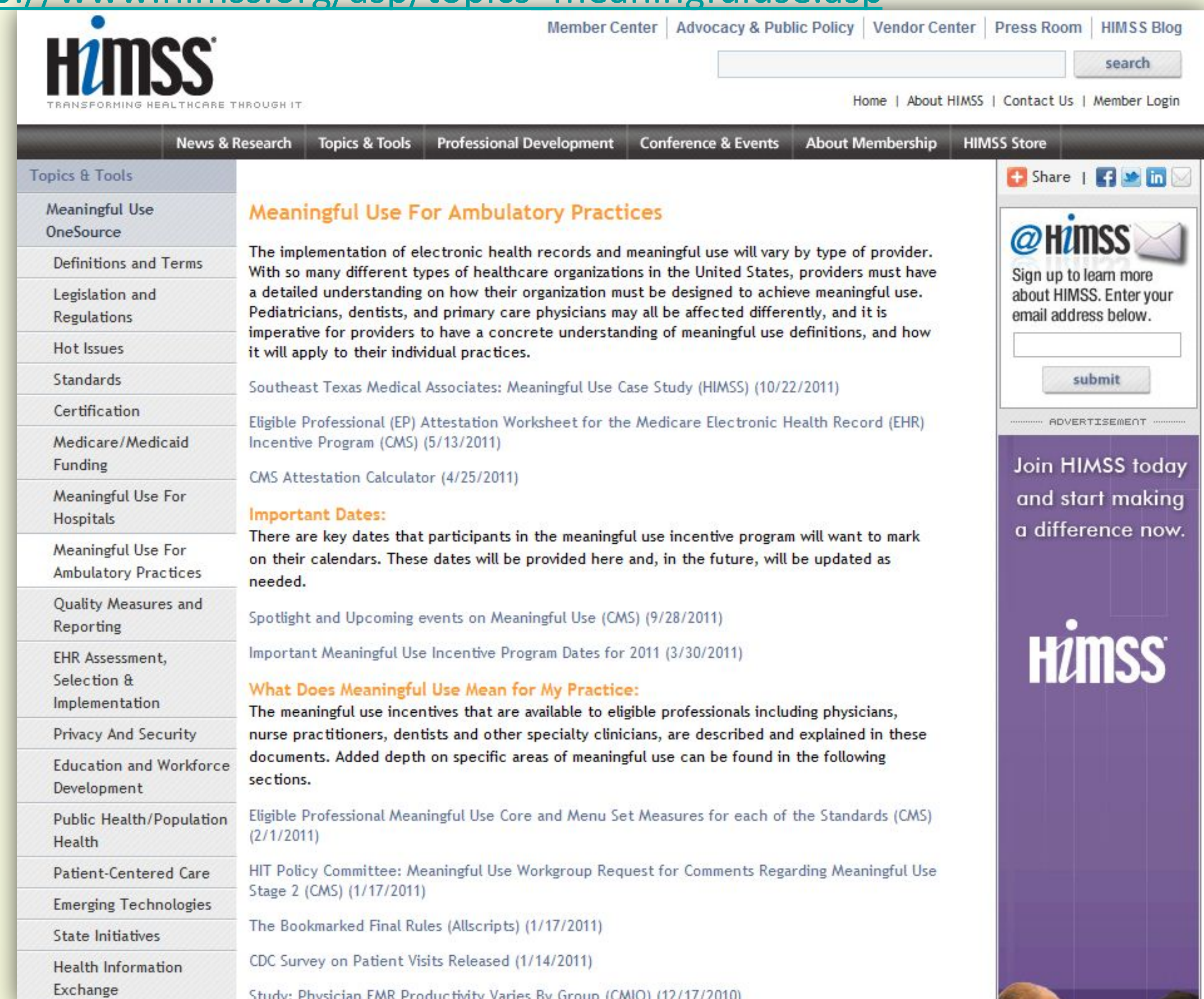
Small Groups

Outline

- Background to the Final Rule
- Financial Incentives for Professionals
- Knowing if Your EHR is Certified
- Elements of Meaningful Use
- Registration and Attestation
- Quality Measures
- Proposed Stage II Criteria
- Capturing the Information
- **Closure**

HIMSS Meaningful Use OneSource

http://www.himss.org/asp/topics_meaningfuluse.asp



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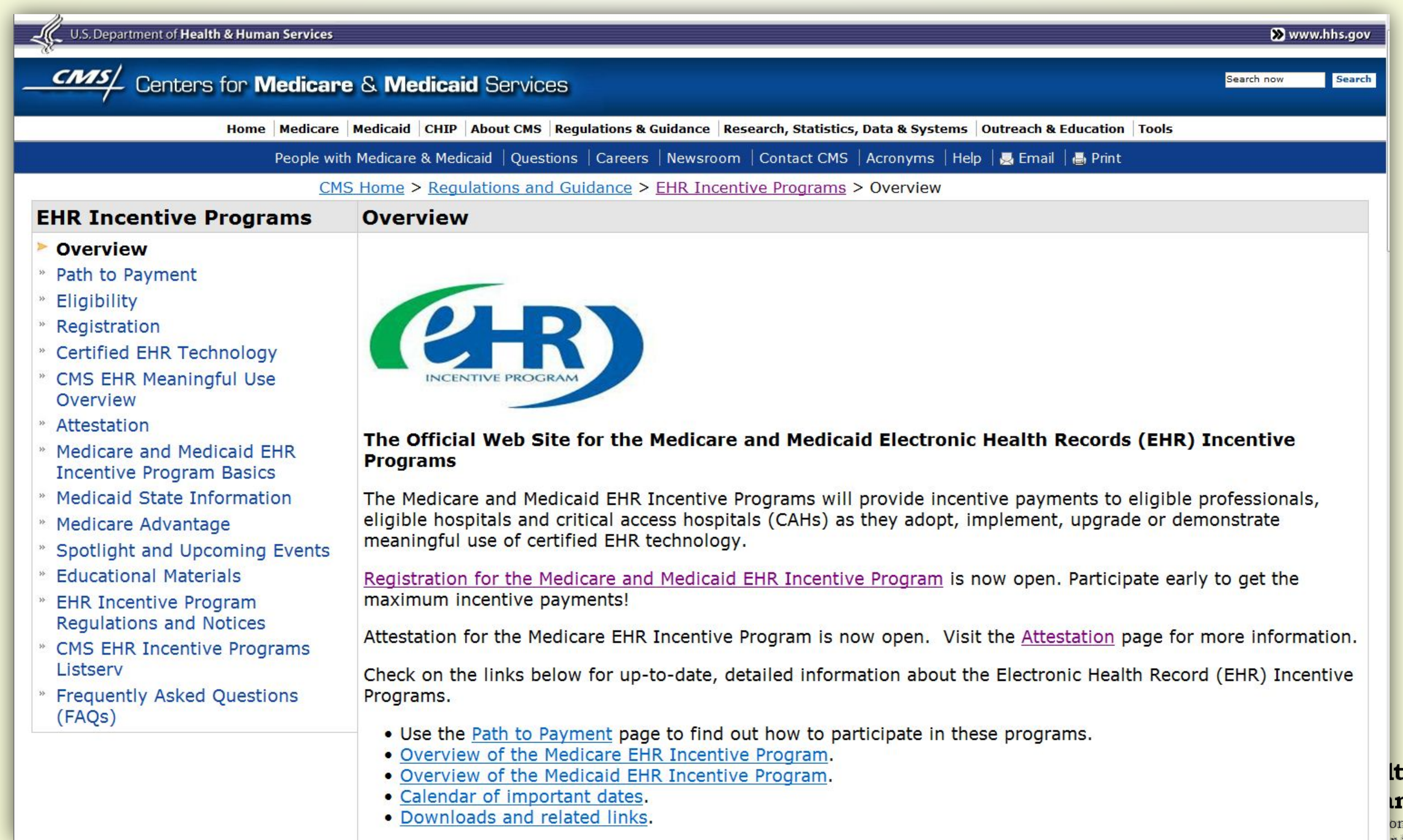
CMS Meaningful Use Website

https://www.cms.gov/EHRIncentivePrograms/



Remediated and Revised CMS FAQs

http://www.cms.gov/EHRIncentivePrograms/Downloads/FAQsRemediatedandRevised.pdf

Electronic Health Record (EHR) Incentive Program FAQs

Table of Contents

Section	Topic of FAQ
I.	**Questions about Getting Started** • EHR Incentive Programs 101 • Payment Questions • Other Getting Started Questions
II.	**Questions about Eligibility for the Programs** • Eligibility Questions for Hospitals • Eligibility Questions for Providers: Who Can Participate • Other Eligibility Questions for Providers
III.	**Medicaid Program for EPs** • Program Requirements • Payment Questions for Medicaid EHR Incentive Program EPs • Meaningful Use Questions
IV.	**Medicaid Program for Hospitals** • Program Requirements and Registration Questions • Payment and Penalty Questions • Meaningful Use Questions • Critical Access Hospital Questions
V.	**Medicare EHR Incentive Program for Hospitals** • Registration Questions • Payment Questions • Meaningful Use Questions • Critical Access Hospital Questions
VI.	**Questions about Certified EHR Technology**
VII.	**Questions about Meaningful Use and Clinical Quality Measures** • General Questions about Meaningful Use & Reporting Period • Questions about Meaningful Use Measures & Objectives
VIII.	**Questions about Attestation**
IX.	**Questions about Payments** • Payment Amounts • Payment Timing • EHR Incentive Payment and Other CMS Program Payments • Other Payment Questions
X.	**Information for States**

Last Updated: October 2011

I. Questions about Getting Started

EHR Incentive Programs 101

1) When do the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs start?

Participation in the Medicare EHR Incentive Program can begin as early as 2011; The incentive program ends in 2016. Registration for the Medicare EHR Incentive Program began on January 3, 2011 and is available online at https://ehrincentives.cms.gov. Attestation is expected to begin in April 2011.The earliest incentive payments to eligible professionals (EPs) and eligible hospitals are expected to be made in May 2011.

Please note that although the Medicaid EHR Incentive Programs will begin January 3, 2011, not all states will be ready to participate on this date. The program will end in 2021. Information on when registration will be available for Medicaid EHR Incentive Programs in specific States is posted at http://www.cms.gov/EHRIncentivePrograms/40_MedicaidStateInfo.asp. Participants in the Medicaid EHR Incentive Program should consult their State for specific information regarding attestation and payment.
Date Updated: 2/17/2011
ID #10080

2) How will eligible professionals (EPs) and eligible hospitals apply for incentives under the Medicare and Medicaid Electronic Health Record (EHR) Incentive Program?

Registration for the Medicare EHR Incentive Program began on January 3, 2011 and is available online at https://ehrincentives.cms.gov. Please note that although the Medicaid EHR Incentive Programs will begin January 3, 2011, not all states will be ready to participate on this date. Information on when registration will be available for Medicaid EHR Incentive Programs in specific States is posted at http://www.cms.gov/EHRIncentivePrograms/40_MedicaidStateInfo.asp.
Date Updated: 1/3/2011
ID #9814

3) When can I register and where do I register for the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs?

Registration for the Medicare EHR Incentive Program began on January 3, 2011 and is available for eligible professionals (EPs), eligible hospitals and critical access hospitals (CAHs) online at https://ehrincentives.cms.gov. Please note that although the Medicaid EHR Incentive Programs will begin January 3, 2011, not all states will be ready to participate on this date. Information on when registration will be available

Last Updated: October 2011

Resources Mentioned in the Talk:

- HIMSS Meaningful Use OneSource
  - http://www.himss.org/asp/topics_meaningfuluse.asp
- North Dakota HIT website:
  - http://www.healthit.nd.gov/
- CMS Websites:
  - Meaningful Use:
    - https://www.cms.gov/EHRIncentivePrograms/
  - Registration instructions for eligible professionals:
    - http://www.cms.gov/EHRIncentivePrograms/20_RegistrationandAttestation.asp
  - Meaningful Use Specification Sheet (A downloadable PDF index that links to the details online)
    - http://www.cms.gov/EHRIncentivePrograms/Downloads/EP-MU-TOC.pdf
  - Remediated and Revised FAQs (a searchable PDF)
    - http://www.cms.gov/EHRIncentivePrograms/Downloads/FAQsRemediatedandRevised.pdf
  - Attestation Worksheet
    - http://www.cms.gov/EHRIncentivePrograms/Downloads/EP_Attestation_Worksheet.pdf
- ONC-ATCB Certified EHRs and what modules they are certified for:
  - http://healthit.hhs.gov/chpl
- Testing criteria for each of the EHR modules:
  - http://healthcare.nist.gov/use_testing/effective_requirements.html
- Quality Measure Specifications on the CMS web site:
  - http://www.cms.gov/QualityMeasures/03_ElectronicSpecifications.asp
- Videos
  - Registration video (with older attestation info):
    - http://www.youtube.com/watch?v=kL-d7zj44Fs
  - New attestation video:
    - http://www.youtube.com/watch?v=B9ftFgLS1fI&feature=relmfu

Other Resources:

- Regional Extension Assistance Center for HIT (REACH):
  - http://khaREACH.org
- Stratis Health HIT Toolkits for clinics:
  - http://www.stratishealth.org/expertise/healthit/clinics/index.html
- "Meaningful Use" information on the Health and Human Services web site:
  - http://healthit.hhs.gov/meaningfuluse/
- Office of the National Coordinator Health IT site:
  - http://HealthIT.gov

In Review

- The EHR Incentive program is intended to encourage the health care industry to improve the quality, safety and efficiency of care through health information technology
- Incentives are available for those who adopt certified EHR technology and use it effectively
- Requirements use will become more demanding over time with demonstrated improvement of quality to be considered for incentives or payment increases
- Efficient and accurate collection of patient information and quality measures as well as improvement will require close attention to workflow
- Use your reports to track your progress in your use of your EHR and to improved quality

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Thank you!

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