Understanding the New EHR Incentive Program Rules

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Regional Extension Assistance Center for HIT

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CMIO Stratis Health

Meaningful Use Bootcamp

January 7, 2013

Introductions

- Your name
- Where you work
- Your role at your facility
- Where you are on the Meaningful Use path
- What you are hoping to learn

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Conflict of Interest

- Dr. Kleeberg is the Clinical Director for the Minnesota - North Dakota Regional Extension Assistance Center for HIT (REACH) – An ONC REC
- Dr Kleeberg also serves on the Physician Advisory Board for Elsevier
- No other conflict of interest

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Objectives

- Understand the new EHR Incentive program rules for Stage 1 and Stage 2
- Know what to do to prepare to meet the new requirements
- Understand the impact this will have on your EHR technology, your staff and your workflow

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Meaningful Use Outline

- **A reminder of why we are doing this**
- Changes to the timeline
- Reminder of the incentives
- Clarification of the Medicare penalties
- New EHR software certification standards for 2014
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From the Health and Human Services Web Site:

- "Health information technology (health IT) makes it possible for health care providers to better manage patient care through secure use and sharing of health information.

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Health Information Technology (HIT) Improves Care (1993 – 1998)

- Tierney, William M., et al. "Physician inpatient order writing on microcomputer workstations." *JAMA: the journal of the American Medical Association* 269.3 (1993): 379-383.↗
  - A randomized controlled clinical trial of order writing on computers resulted in
    - **Charges that were 12.7%** lower per admission
    - Significant reductions for bed charges, diagnostic test charges and drug charges.
    - A mean length of stay was 0.89 day shorter
- Evans, R. Scott, et al. "Improving empiric antibiotic selection using computer decision support." *Archives of Internal Medicine* 154.8 (1994): 878.↗
  - Random-selection study to compare antibiotics suggested by the antibiotic consultant with those ordered by physicians demonstrated a **17% greater pathogen susceptibility** to an antibiotic drug regimen suggested by a computer consultant vs. a physician
- Evans, R. Scott, et al. "A computer-assisted management program for antibiotics and other anti-infective agents." *New England Journal of Medicine* 338.4 (1998): 232-238. ↗
  - Pre and post intervention study alerting for drug allergies, excessive dosages, antibiotic-susceptibility, lack of appropriateness and patients' renal function
  - Faster retrieval of relevant patient-specific information 14 minutes vs. 3.5 seconds
  - **Reductions in erroneous orders** for drugs where the patients had
    - Adverse Drug Event 70%
    - Reported allergies: 76%
    - Excess drug dosages 79%
    - Antibiotic-susceptibility mismatches 94%

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CPOE Decreases Medication Errors (1998 – 2001)

- Bates, David W., et al. “Effect of computerized physician order entry and a team intervention on prevention of serious medication errors.” *JAMA: the journal of the American Medical Association* 280.15 (1998): 1311-1316.↗
  - Assessing the impact of CPOE with CDSSs in a before-after comparison study demonstrated a **55% decrease in non intercepted serious medication errors**
- Bates, David W., et al. “The impact of computerized physician order entry on medication error prevention.” *Journal of the American Medical Informatics Association* 6.4 (1999): 313-321.↗
  - Evaluated medication error rates before CPOE and in the 3 years subsequent to its implementation. It demonstrated an 81% decrease in medication errors and an **86% decrease in non intercepted serious medication errors** (*P*<.001 for both)
- Overhage, J. Marc, et al. “A randomized trial of “corollary orders” to prevent errors of omission.” *Journal of the American Medical Informatics Association* 4.5 (1997): 364-375.↗
  - Greater than **25% improvement in the rates of corollary orders** with implementation of computerized reminders.

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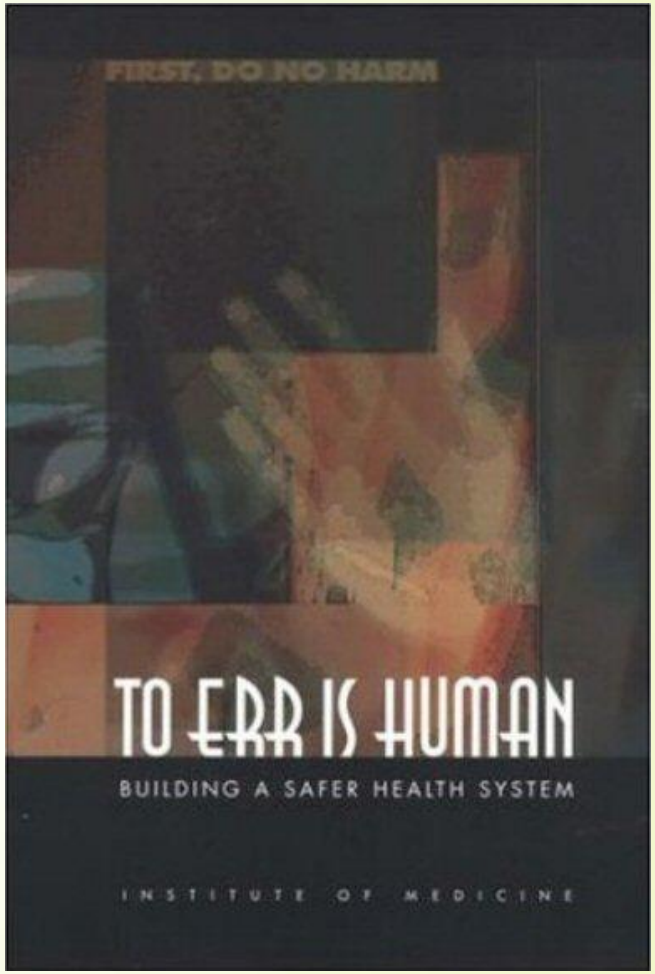
Institute of Medicine, Sept 1999

- At least 44,000 people, and perhaps as many as 98,000 people, die in hospitals each year as a result of medical errors that could have been prevented
- Using the lower estimate, preventable medical errors in hospitals exceed attributable deaths to such feared threats as motor-vehicle wrecks, breast cancer, and AIDS.
- The equivalent of one jumbo jet falling out of the sky every day



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Continued Evidence of CPOE Benefits Pre/Post Intervention Studies (2002-2005)

- Mekhjian, Hagop S., et al. "Immediate benefits realized following implementation of physician order entry at an academic medical center." *Journal of the American Medical Informatics Association* 9.5 (2002): 529-539.↗
  - A 64% improvement in medication **turn-around times**, 43% in radiology procedure completion times, and 25% in laboratory result reporting times
- Holdsworth, Mark T., et al. "Impact of computerized prescriber order entry on the incidence of adverse drug events in pediatric inpatients." *Pediatrics* 120.5 (2007): 1058-1066.↗
  - A 43% reduction in preventable ADEs and **63% reduction in potential ADEs**
- Potts, Amy L., et al. "Computerized physician order entry and medication errors in a pediatric critical care unit." *Pediatrics* 113.1 (2004): 59-63. ↗
  - An overall **error reduction of 95.9%** with ADEs reduced by 40.9%, Medication prescribing errors reduced by 99.4% and rule violations reduced by 97.9%.
- Kucher, Nils, et al. "Electronic alerts to prevent venous thromboembolism among hospitalized patients." *New England Journal of Medicine* 352.10 (2005): 969-977. ↗
  - **Reduced risk of deep-vein thrombosis** or pulmonary embolism at 90 days by 41%

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Health Information Technology and Quality, Efficiency and Cost (2006)

- Wu, Shinyi, et al. “Systematic review: impact of health information technology on quality, efficiency, and costs of medical care.” *Annals of internal medicine* 144.10 (2006): 742-752.↗
- 257 studies met the inclusion criteria of which 25% were from 4 academic institutions with internally developed systems
  - Brigham and Women's Hospital in Boston
  - LDS Hospital in Salt Lake City
  - Vanderbilt University Medical Center in Nashville
  - The Regenstrief Institute in Indianapolis
- Those 4 institutions (and only those 4) demonstrated
  - Benefits on quality:
    - Increased adherence to guideline-based care
    - Enhanced surveillance and monitoring
    - Decreased medication errors.
  - Benefit of improvement
    - Preventive health (DVT, pressure ulcers and post-op infections)
  - Efficiency benefit
    - Decreased utilization of care.

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EHRs: Problems with Commercial Installations (2005 – 2009)

- Han YY, Carcillo JA, Venkataraman ST, et al. Unexpected increased mortality after implementation of a commercially sold computerized physician order entry system. *Pediatrics*. 2005;116(6):1506–1512
  - The rapid implementation of a minimally modified, commercially available CPOE system in a pediatric critical care unit was associated with an **increase in mortality rate** for children admitted via interfacility transport over a 5-month period.
- Linder, Jeffrey A., et al. "Electronic health record use and the quality of ambulatory care in the United States." *Archives of Internal Medicine* 167.13 (2007): 1400-1405.
  - Evaluated 50,000 patient records from over 1500 physician practices in 2003 and 2004 and found: "As implemented, EHRs were **not associated with better quality** ambulatory care."
  - Acknowledged the positive information came from 4 "benchmark" institutions

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Local Customization of CPOE Improves Quality (2010 – 2012)

- Longhurst, Christopher A., et al. “Decrease in hospital-wide mortality rate after implementation of a commercially sold computerized physician order entry system." *Pediatrics* 126.1 (2010): 14-21. ↗
  - Pre and Post implementation of a locally modified CPOE and electronic nursing documentation system at quaternary care academic children's hospital demonstrated a monthly adjusted **mortality rate decreased by 20%**
- Bright, Tiffani J., et al. “Effect of clinical decision-support systems: a systematic review.” *Annals of internal medicine* 157.1 (2012): 29-43. ↗
  - A review of 148 randomized, controlled trials of electronic CDSSs implemented in clinical settings, used at the point of care and reported either clinical, health care process, workload, relationship-centered, economic, or provider use outcomes.
  - Both **commercially and locally developed clinical decision-support systems (CDSSs) showed statistical significance in improved health care process measures** related to performing preventive services, ordering clinical studies and prescribing therapies across diverse settings.

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EHRs and Quality (2012)

- Haut, Elliott R., et al. “Improved Prophylaxis and Decreased Rates of Preventable Harm With the Use of a Mandatory Computerized Clinical Decision Support Tool for Prophylaxis for Venous Thromboembolism in Trauma Patients.” *Archives of Surgery* 147.10 (2012): 901-907. ↗
  - Retrospective cohort study of trauma patients demonstrated Increased mechanical prophylaxis (10.0% vs. 1.5%, increased pharmacologic prophylaxis (23.6% vs. 13.%) and **reduced risk of deep-vein thrombosis or pulmonary embolism at 90 days by 41%**.
- Kern, Lisa M., et al. "Electronic Health Records and Ambulatory Quality of Care." *Journal of General Internal Medicine* (2012): 1-8. ↗
  - Study compared physicians using EHRs to physicians using paper on performance for each of the nine quality measures
  - EHRs were associated with **significantly higher quality of care** for hemoglobin A1c testing in diabetes, breast cancer screening, chlamydia screening and colorectal cancer screening
  - When all nine measures were combined into a composite, EHR use was associated with statistically significant higher quality of care
- Reed, M., et al. “Outpatient electronic health records and the clinical care and outcomes of patients with diabetes mellitus.” *Annals of internal medicine* 157.7 (2012): 482. ↗
  - Statistically significant improvements in treatment intensification after HbA1c ≥ 9% or LDL-C values of 100 to 129 mg/dL
  - Increases in 1-year retesting for HbA1c and LDL-C levels among all patients
  - Decreased 90-day retesting among controlled patients with HbA1c levels <7% and LDL-C levels <100 mg/dL
  - **Statistically significant reductions in HbA1c and LDL-C levels**, with the largest reductions among patients with the worst control

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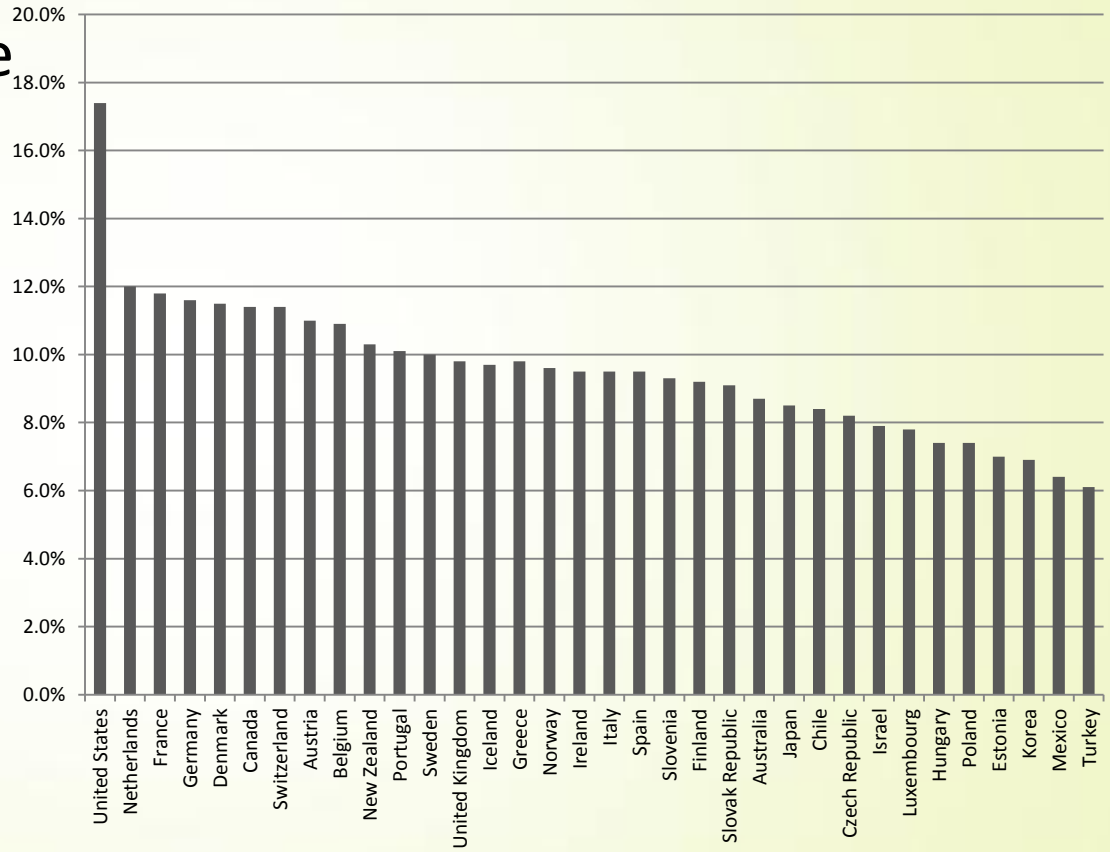
Are we getting value for our dollar? Cost vs. Quality

- Per capita health care spending[1]
  - $2.6T (2010)
  - 17.9% GDP
  - $8,402 per person
- 2009 Life expectancy as a surrogate for quality: 25th of 33 countries[2]

Spending as a % of GDP[3]



[1] CMS Health Expenditures 1960-2010 (http://www.cms.gov/NationalHealthExpendData/downloads/nhegdp10.zip)
[2] Organization for Economic and Co-operation and Development (http://stats.oecd.org/index.aspx?DataSetCode=HEALTH_STAT)
[3] OECD Health Data 2011: http://www.oecd.org/document/16/0,3343,en_2649_34631_2085200_1_1_1_1,00.html

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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

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Meaningful Use Outline

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Stages of Meaningful Use Once you Attest

First Attestation Year	Stage of Meaningful Use										
	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021
2011	1	1	1	2	2	3	3	TBD	TBD	TBD	TBD
2012		1	1	2	2	3	3	TBD	TBD	TBD	TBD
2013			1	1	2	2	3	3	TBD	TBD	TBD
2014				1	1	2	2	3	3	TBD	TBD
2015					1	1	2	2	3	3	TBD
2016						1	1	2	2	3	3
2017							1	1	2	2	3

1. Note: These stages will continue to progress whether or not you attest to meaningful use in any year following your first attestation year

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Incentives

- Some broadening of Medicaid eligibility
- Medicare and Medicaid Incentives are unchanged from the Stage 1 Rule

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Medicaid Changes

- Service rendered on any one day to a Medicaid-enrolled individual, regardless of payment liability
- CHIP encounters for patients in Title 19 and Title 21 Medicaid expansion programs (not stand-alone CHIP)
- States may allow providers to calculate Medicaid (or needy individual) patient volume across 90-day period in last 12 months preceding attestation

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Maximum Medicare Incentives for EPs[1]

1st Attest	2011	2012	2013	2014	2015	2016	2017	Total
2011	Stage 1 $18k	Stage 1 $12k	Stage 1 $8k	Stage 2 $4k	Stage 2 $2k	Stage 3	Stage 3	$44k
2012		Stage 1 $18k	Stage 1 $12k	Stage 2 $8k	Stage 2 $4k	Stage 3 $2k	Stage 3	$44k
2013			Stage 1 $15k	Stage 1 $12k	Stage 2 $8k	Stage 2 $4k	Stage 3	$39k
2014				Stage 1[2] $12k	Stage 1 $8k	Stage 2 $4k	Stage 2	$24k
2015					Stage 1[2]	Stage 1	Stage 2	0
Penalty (deduction from Medicare charges) if not a meaningful user:					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
2. Must demonstrate and attest to MU by October 1 to avoid the penalty in the next year

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Maximum Medicaid Incentives for EPs with ≥30% volume

First Year of Adopt, implement, Upgrade or MU Demonstration	Calendar Year											
	2011	2012	2013	2014	2015[1]	2016[1]	2017[1]	2018[1]	2019[1]	2020[1]	2011[1]	Total
2011	$21,250	$8,500	$8,500	$8,500	$8,500	$8,500						$63,750
2012		$21,250	$8,500	$8,500	$8,500	$8,500	$8,500					$63,750
2013		$21,250		$8,500	$8,500	$8,500	$8,500		$8,500			$63,750
2013		$21,250	$8,500		$8,500		$8,500		$8,500		$8,500	$63,750
2013			$21,250	$8,500	$8,500	$8,500	$8,500	$8,500				$63,750
2014				$21,250	$8,500	$8,500	$8,500	$8,500	$8,500			$63,750
2015[1]					$21,250	$8,500	$8,500	$8,500	$8,500	$8,500		$63,750
2016[1]						$21,250	$8,500	$8,500	$8,500	$8,500	$8,500	$63,750
2017[1]							$0					$0

1. Note: Medicare penalties will apply for any of the professional's billing to Medicare part B if not a meaningful user

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Medicare Incentives for Prospective Payment System (PPS) Hospitals[1]

Attest Year	2011	2012	2013	2014	2015	2016	2017	% Max Payment
2011	Stage 1 100%	Stage 1 75%	Stage 1 50%	Stage 2 25%	Stage 2	Stage 3	Stage 3	100%
2012		Stage 1 100%	Stage 1 75%	Stage 2 50%	Stage 2 25%	Stage 3	Stage 3	100%
2013			Stage 1 100%	Stage 1 75%	Stage 2 50%	Stage 2 25%	Stage 3	100%
2014				Stage 1[2] 75%	Stage 1 50%	Stage 2 25%	Stage 2	60%
2015					Stage 1[2] 50%	Stage 1 25%	Stage 2	30%
2016						Stage 1[2]	Stage 1	0%
Penalties: Market basket update would be reduced by:					-25%	-50%	-75%	

1. Percentages in the cells indicate the transition factor for the Medicare Share incentive
2. Must demonstrate and attest to MU by July 1, to avoid the penalty in the next year.

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Medicare Incentives for Eligible Critical Access Hospitals

Attest Year	2011	2012	2013	2014	2015	2016	2017	# of Payments
2011	Stage 1 Payment	Stage 1 Payment	Stage 1 Payment	Stage 2 Payment	Stage 2	Stage 3	Stage 3	4
2012		Stage 1 Payment	Stage 1 Payment	Stage 2 Payment	Stage 2 Payment	Stage 3	Stage 3	4
2013			Stage 1 Payment	Stage 1 Payment	Stage 2 Payment	Stage 2	Stage 3	3
2014				Stage 1 Payment	Stage 1 Payment	Stage 2	Stage 2	2
2015					Stage 1 Payment	Stage 1	Stage 2	1
2016						Stage 1	Stage 1	0
Penalties: Reasonable cost reimbursement of 101% would be reduced to:					100.66%	100.33%	100%	

Incentive payments calculation based on the Medicare Share of the EHR cost

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Maximum Medicaid Incentives for Eligible / Critical Access Hospitals

First Year of Adopt, implement, Upgrade or MU Demonstration	Calendar Year								
	2011	2012	2013	2014	2015[1]	2016[1]	2017[1]	2018[1]	Total
2011	50%	40%	10%						Percentage is total of calculated 3 year EHR costs
2011	50%		40%	10%					
2011	50%		40%			10%			
2012		50%	40%	10%					
2013			50%	40%	10%				
2014				50%	40%	10%			
2015[1]					50%	40%	10% [2]		
2016[1]						50%	40% [2]	10%	
2017[1]							0%		

1. Note: Medicare penalties will apply for any of the hospital's charges if not a meaningful user
2. Any payment year skipped after 2016 will end the payment program for that facility

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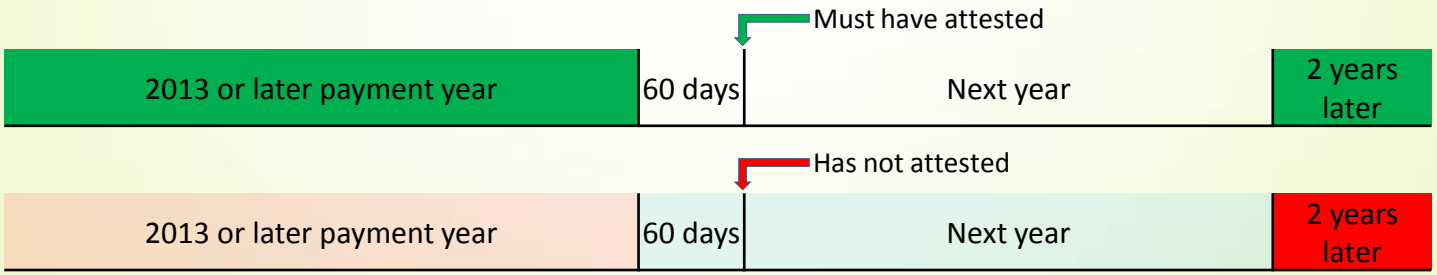
EP and EH (not CAH) Requirements for Those Who Attested in 2011 or 2012

- If an EP or EH attested to MU in the 2011 or 2012 payment years (EH: fed fiscal; EP: calendar)
  - Required to be a MUser each year after that or experience a Medicare payment penalty 2 years later



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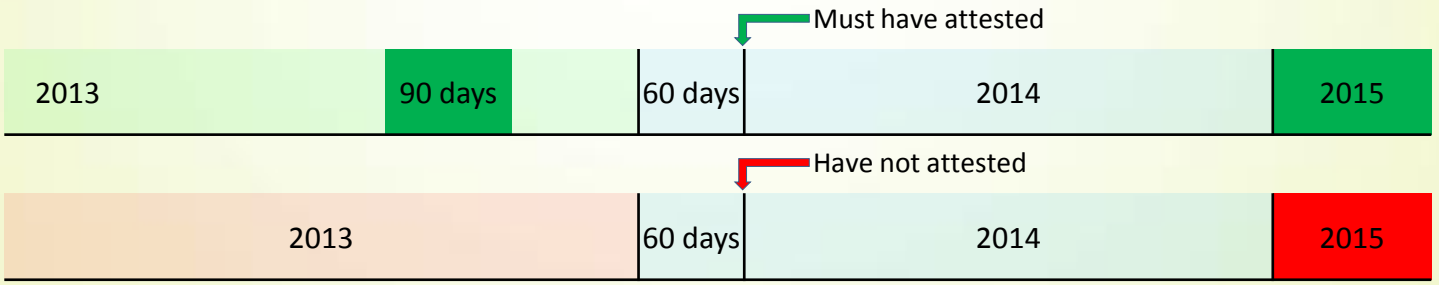
EP and EH (not CAH) Requirements for Those Who First Attest in 2013

- If an EP or EH demonstrates MU in the 2013 payment year for the first time:
  - They may use any 90 day period in 2013
  - They must attest within 60 days of the end of the measurement period
  - They must be a MUser each year after that or be penalized by Medicare 2 years after the missed year



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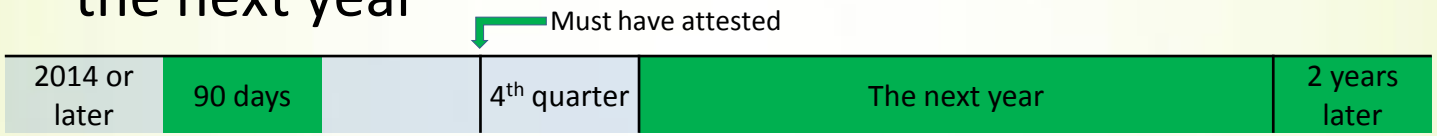
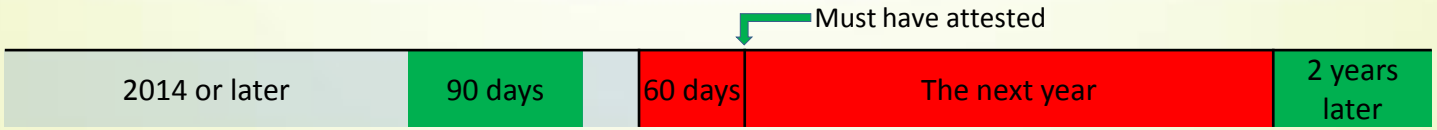
EP and EH (not CAH) Requirements for Those Who First Attest in 2014 or later

- If an EP or EH demonstrates MU in the 2014 or later for the first time:
  - Must complete their 90 days and attest no later than 3 months before the end of the payment year (EPs: October 1; EHs July 1) or be subject to the penalty in the next year



  - If they attest anytime after the start of the last three months of the payment year but within 60 days of the end of the payment year, they will be subject to the penalty in the next year but not two years later



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EP Medicare Payment Adjustments Unchanged From Stage 1 Rule

- For the EP starting in 2015:
  - If > 75% of EPs are meaningful users, allowable charges will be reduced 1%/year to a max of 3%
  - If < 75% of EPs are meaningful users, again 1%/year with a maximum reduction of 5%
- For EHs:
  - Market basket update would be reduced by 25%/year to a max of 75%

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Critical Access Hospital Payment Adjustments Unchanged from Stage 1

- CAHs use an EHR reporting period aligned with the payment adjustment year.
  - If a CAH is not a meaningful EHR user in FY 2015, then its Medicare reimbursement will be reduced for its cost reporting period that begins in FY 2015.
- Reasonable costs reimbursement (normally 101%) would be reduced by .33% starting in 2015 to 100% by 2017 and thereafter

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EP and EH/CAH Hardship Exceptions

Providers can apply for hardship exceptions in the following categories:

- Infrastructure
  - In sufficient internet access or face insurmountable barriers to obtaining infrastructure (e.g., lack of broadband).
- Unforeseen Circumstances
  - Natural disaster or other unforeseeable barrier.

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Additional EP Hardship Exceptions

- New EPs
  - Newly practicing EPs can apply for a 2-year limited exception to payment adjustments.
- EPs who demonstrate that they meet the following criteria:
  - Lack of face-to-face or telemedicine interaction with patients
  - Lack of follow-up need with patients
- EPs who practice at multiple locations demonstrate that they:
  - Lack of control over availability of CEHRT for more than 50% of patient encounters

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Additional EH and CAH Hardship Exceptions

- New Eligible Hospitals or CAHs can apply for a limited exception to payment adjustments.
  - For CAHs one full year after it accepts its first Medicare patient.
  - For eligible hospitals one full-year cost reporting period after it accepts its first Medicare patient.

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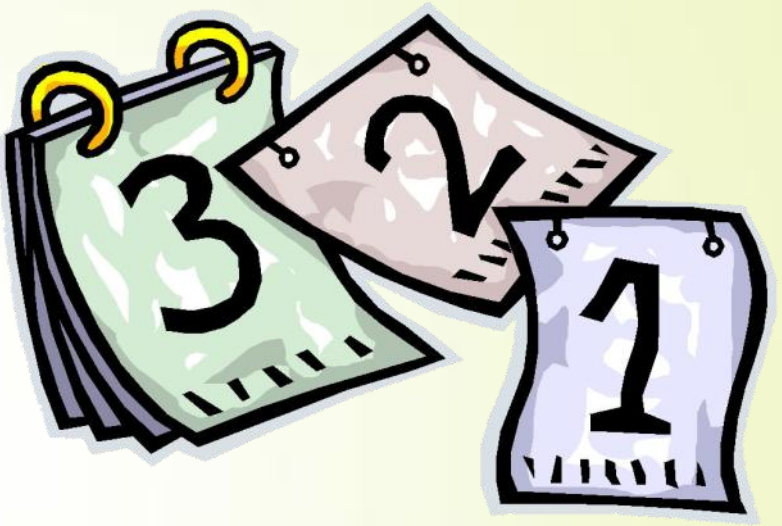
Applying for Hardship Exceptions



- EPs, EHs, and CAHs must apply each year to avoid the payment adjustments.
- Applications need to be submitted by April 1 for hospitals, and July 1 for EPs of the year before the payment adjustment year
- Granted if providers demonstrate that those circumstances pose a significant barrier to their achieving meaningful use.
- Details will be posted on the CMS EHR Incentive Programs website in the future:
  - www.cms.gov/EHRIncentivePrograms

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Questions

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Essential Changes in EHR Certification

- EHR Certification:
  - From "Stage 1 Certified" ➔ 2011 Certification
  - New Certification criteria ➔ 2014 Certification
- All will need to have 2014 Certified EHR Technology (CERT) in payment year 2014
- ONC/CMS will not require an EP/EH CAH to purchase components they do not need
- Vendors will not need to recertify on criteria that have not changed since 2011
- New Criteria: Safety-enhanced design

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Certified EHR Technology

What it is today

2011 - 13

What it will be

2014

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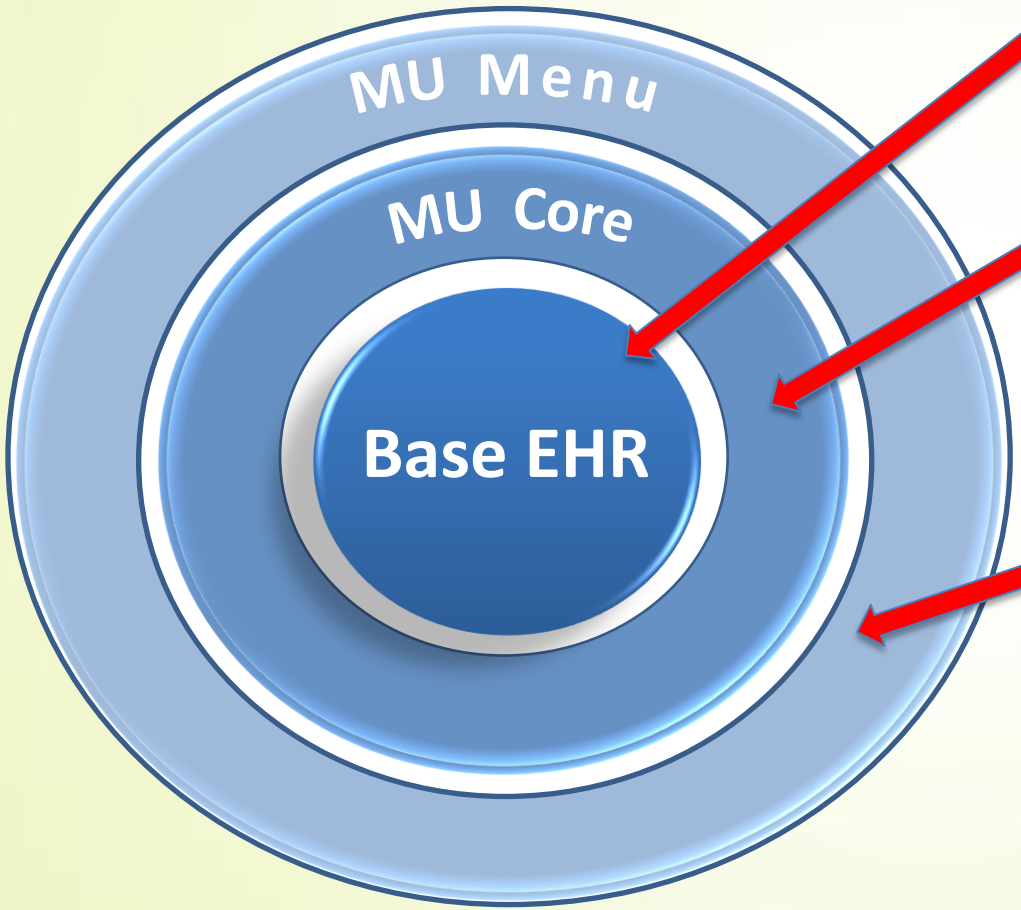
2014 Edition CEHRT



Base: Capabilities certified to meet the definition of Base EHR.

Core: Capabilities certified for the MU core objectives & measures for the stage of MU they seek to achieve unless the EP/EH/CAH meets an exclusion.

Menu: Capabilities certified for the MU menu set objectives & measures for the stage of MU they seek to achieve as well as the selected quality measures

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"Base EHR"

- EHR technology that includes fundamental capabilities all providers would need to have.
- Defined by statute:
  - Demographics
  - CPOE
  - CDS
  - Quality Reporting
  - Information exchange
- Security requirements, though not required by statute, were added to the base EHR

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Base EHR

Certification Criteria Required to Satisfy the Definition of a Base EHR	
Base EHR Capabilities	**Certification Criteria**
Includes patient demographic and clinical health information, such as medical history and problem lists	Demographics § 170.314(a)(3) Problem List § 170.314(a)(5) Medication List § 170.314(a)(6) Medication Allergy List § 170.314(a)(7)
Capacity to provide clinical decision support	Clinical Decision Support § 170.314(a)(8)
Capacity to support physician order entry	Computerized Provider Order Entry § 170.314(a)(1)
Capacity to capture and query information relevant to health care quality	Clinical Quality Measures § 170.314(c)(1) and (2)
Capacity to exchange electronic health information with, and integrate such information from other sources	Transitions of Care § 170.314(b)(1) and (2)
	Data Portability § 170.314(b)(7)
Capacity to protect the confidentiality, integrity, and availability of health information stored and exchanged	Privacy and Security § 170.314(d)(1) through (8)

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Definition of CEHRT Compliance

EHR Reporting Period			
FY/CY 2011	**FY/CY 2012**	**FY/CY 2013**	**FY/CY2014**
MU Stage 1	MU Stage 1	MU Stage 1	MU Stage 1 or MU Stage 2
EHR technology certified to 2011 Edition EHR certification criteria or equivalent 2014 Edition EHR certification criteria			EHR technology certified to the 2014 certification criteria meeting the Base EHR definition and supports the objectives, measures, and CQMs, for the stage that they seek to achieve.

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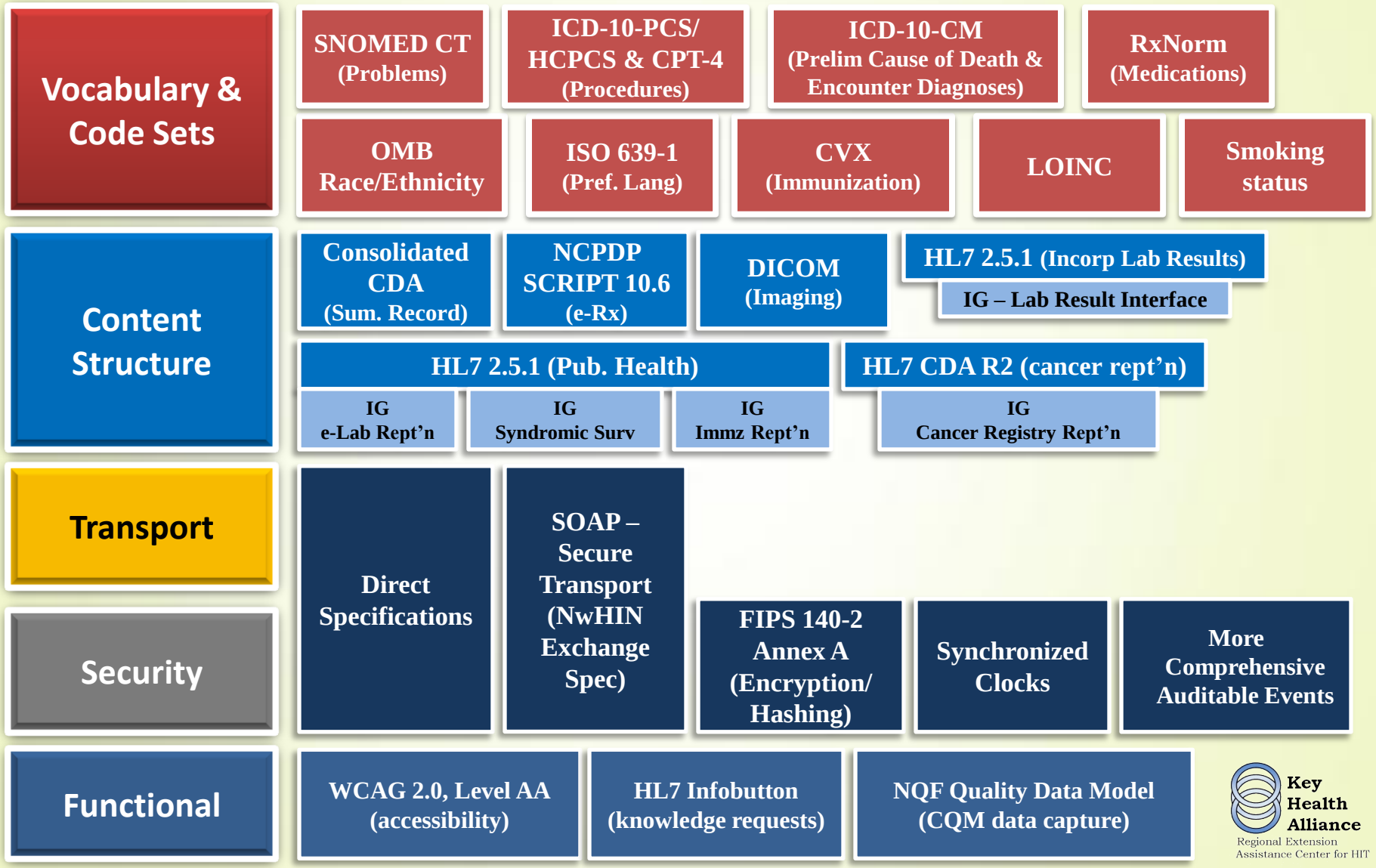
2014 Edition Standards



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Meaningful Use Outline

- A reminder of why we are doing this
- Changes to the timeline
- Reminder of the incentives
- Clarification of the Medicare penalties
- New EHR software certification standards for 2014
- **New and revised functional criteria requirements for Stages 1 & 2**
- New quality measurement requirements starting in 2014
- What you need to do now

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Important Changes to Meaningful Use

- Starting in 2014
  - Menu objective exclusions will no longer count towards the number of menu objectives needed.
- For all in the 2014 reporting year:
  - Reporting period reduced to a fiscal or calendar quarter
    - To allow providers time to adopt 2014 certified EHR technology and prepare for Stage 2
    - To allow quality measures to correspond with reporting requirements of other quality reporting programs

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Stage 1 and Stage 2 Meaningful Use for 2014

Eligible Professionals

13 core objectives

5 of 9 menu objectives

18 total objectives

Eligible Professionals

17 core objectives

3 of 6 menu objectives

20 total objectives

Eligible Hospitals & CAHs

11 core objectives

5 of 10 menu objectives

16 total objectives

Eligible Hospitals & CAHs

16 core objectives

3 of 6 menu objectives

19 total objectives

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Changes to Stage 1

- CPOE:
  - Starting in 2013 option of 30% of all medication orders
- Vital Signs:
  - Optional in 2013 and required in 2014:
    - ≥ 3 for BP; all ages for height/length & weight; growth charts ≤ 20
    - May claim exclusion for H/L&W or BP or both
- Test of exchange and the yes/no measure "Reporting CQMs":
  - Removed starting in 2013
- Electronic copies and access:
  - 2 EP and 2 EH measures replaced in 2014 with online view, download and transmit
- Public Health Measures:
  - "…except where prohibited…" added to the requirements

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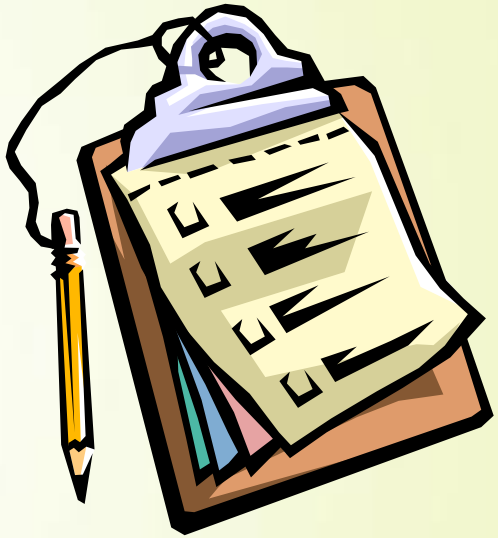
Concepts for Stage 2

- In general:
  - Stage 1 menu items have become core
  - Percentages have increased
  - Turnaround time is shorter
  - More exchange
  - More patient online access and involvement
  - Some core measures incorporated into other activities



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Demographics

Stage 1 (Core)

- Measure
  - >50% of patients seen: preferred language, gender, race, ethnicity, and DOB. For EHs: date and preliminary cause of death
- Denominator
  - Unique Patients
- Exclusion
  - None

Stage 2 (Core)

- Measure
  - ***>80%*** of patients seen: preferred language, ***sex***, race, ethnicity, DOB. For EHs: date and preliminary cause of death
- Denominator
  - Unique Patients
- Exclusion
  - None

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Vital Signs

Stage 1 (Core)

- Measure
  - >50% of patients ≥ 2yo seen: height, weight, BP, BMI, & for age 2-20: growth charts w/BMI. ***May split BP and height-weight, also may use only ≥ 3 for BP and all ages for H/W/BMI)***
- Denominator
  - Unique patients
- Exclusion
  - EP: If outside scope of practice
  - EH: None

Stage 2 (Core)

- Measure
  - ***>80%*** of patients height/length, weight, BMI; ***≥ 3yo***: BP; age ***0-20***: growth charts w/BMI. May split BP and height/length-weight
- Denominator
  - Unique Patients
- Exclusion
  - EP: If BP or H/L-W is outside scope of practice
  - EH: None

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Problem List

Stage 1 (Core)

- Measure
  - >80% of patients seen at least one or “none” as structured data
- Denominator
  - Unique patients
- Exclusion
  - None

Stage 2

- Measure
  - Incorporated as a mandatory element in the transfer of care document
- Denominator
  - Referrals or transfers of care
- Exclusion
  - None

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Medication List

Stage 1 (Core)

- Measure
  - >80% of patients seen at least one or “none” as structured data
- Denominator
  - Unique patients
- Exclusion
  - None

Stage 2

- Measure
  - Incorporated as a mandatory element in the transfer of care document
- Denominator
  - Referrals or transfers of care
- Exclusion
  - None

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Medication Reconciliation

Stage 1 (Menu)

- Measure
  - >50% of transitions of care or a relevant encounter
- Denominator
  - # of transitions of care (***and relevant encounters if there is a policy***)
- Exclusion
  - EP: No transitions of care or referrals received
  - EH: None

Stage 2 ***(Core)***

- Measure
  - >50% of transitions of care or a relevant encounter
- Denominator
  - # of transitions of care (and relevant encounters if there is a policy)
- Exclusion
  - EP: No transitions of care or referrals received
  - EH: None

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Medication Allergies

Stage 1 (Core)

- Measure
  - >80% of patients seen at least one or “none” as structured data
- Denominator
  - Unique patients
- Exclusion
  - None

Stage 2

- Measure
  - Incorporated as a mandatory element in the transfer of care document
- Denominator
  - Referrals or transfers of care
- Exclusion
  - None

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Smoking Status

Stage 1 (Core)

- Measure
  - >50% of patients ≥ 13yo seen, record status as structured data
- Denominator
  - Unique patients
- Exclusion
  - No patients 13 years old or older.

Stage 2 (Core)

- Measure
  - ***>80%*** of patients ≥ 13yo seen, record status as structured data
- Denominator
  - Unique patients
- Exclusion
  - No patients 13 years old or older.

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Family Health History

Stage 1

- None

Stage 2 (Menu)

- Measure
  - >20% have a structured data entry for one or more first-degree relatives
- Denominator
  - Unique patients
- Exclusion
  - EH: None
  - EP: No office visits

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Advanced Directives (EH)

Stage 1 (Menu)

- Measure
  - >50% of ≥65yo admitted indicate advanced directive recorded
- Denominator
  - Unique inpatient admissions
- Exclusion
  - No patients ≥65yo admitted

Stage 2 (Menu)

- Measure
  - >50% of ≥65yo admitted indicate advanced directive recorded
- Denominator
  - Unique inpatient admissions
- Exclusion
  - No patients ≥65yo admitted

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Computerized Provider Order Entry (CPOE)

Stage 1 (Core)

- Measure
  - >30% of patients on any meds with ≥ one CPOE med order ***or may use >30% all orders***
- Denominator
  - Unique patients ***or unique orders***)
- Exclusion:
  - Any EP who writes <100 medication orders during the EHR reporting period.

Stage 2 (Core)

- Measures
  - ***>60%*** of all medication orders, ***>30% of all laboratory and >30% radiology orders*** must be entered using CPOE
- Denominators:
  - Unique orders
- Exclusions:
  - Any EP who writes <100 medication, <100 radiology, or <100 laboratory orders during the EHR reporting period.

Starting in 2013, any licensed healthcare professionals and ***credentialed medical assistants***, can enter orders into the medical record for purposes of including the order in the numerator for the objective of CPOE if they can originate the order per state, local and professional guidelines.

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Drug Formulary Check

Stage 1 (Menu)

- Measure
  - Implement drug formulary checks with at least one internal or external formulary
- Denominator
  - Yes/No Attest
- Exclusion
  - EP: writes <100 medication orders during the EHR reporting period
  - EH: None

Stage 2

- Measure
  - EP: Incorporated into the eRx core item
  - EH: Incorporated into the eRx menu item

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Drug-Drug and Drug-Allergy Interaction Checks

Stage 1 (Core)

- Measure
  - This functionality is enabled for the entire EHR reporting period
- Denominator
  - Yes/No Attest
- Exclusion
  - None

Stage 2

- Incorporated into the Clinical Decision Support Measure:
  - This functionality is enabled for the entire EHR reporting period

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Clinical Decision Support

Stage 1 (Core)

- Measure
  - 1 CDS rule relevant to the specialty specific quality metric (EP) or high priority hospital condition (EH) with the ability to track compliance
- Denominator
  - Yes/No Attest
- Exclusion
  - None

Stage 2 (Core)

- Measures
  - ***5*** CDS ***interventions*** relevant to 4 quality metrics or high priority condition
  - Drug-drug and drug-allergy interactions turned on
- Denominator
  - Yes/No Attest
- Exclusion
  - EP: D-D/D-A only if writes <100 medication orders

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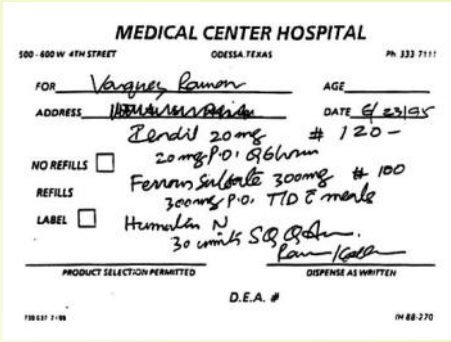
ePrescribing (EP)


MEDICAL CENTER HOSPITAL
500 - 600 W 4TH STREET ODESSA, TEXAS Ph. 333 7111
FOR Vasquez, Ramon AGE
ADDRESS DATE 6/23/05
Zestril 20 mg # 120 –
20 mg P.O. Q 6 hrs
NO REFILLS ☐ Fenoxy Sulfonate 300 mg # 100
REFILLS 300 mg P.O. TID ℈ meals
LABEL ☐ Humulin N
30 units SQ
PRODUCT SELECTION PERMITTED DISPENSE AS WRITTEN
D.E.A. #

Stage 1 (Core)

- Measure
  - >40% of permissible scripts are generated and transmitted electronically
- Denominator
  - Number of permissible (non-controlled substance) scripts written by the EP
- Exclusion
  - Any EP who writes <100 prescriptions during the EHR reporting period.

Stage 2 (Core)

- Measure
  - ***>50*** percent of permissible or all prescriptions written are queried for a drug formulary and transmitted electronically
- Denominator
  - Number of permissible ***or all*** scripts written by the EP
- Exclusion
  - Any EP who writes <100 ***permissible*** prescriptions during the EHR reporting period.
  - ***No pharmacies that accept e-prescriptions within 10 miles***

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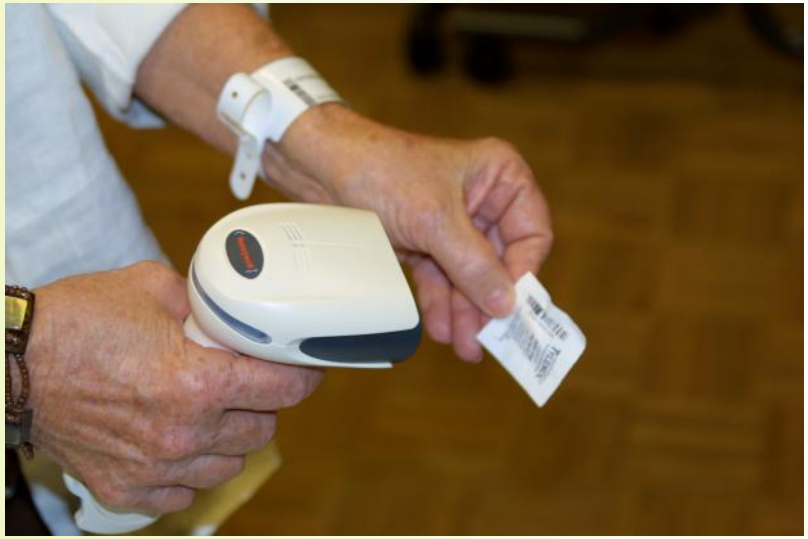
Electronic Medication Tracking eMAR (EH)

Stage 1

- None



Stage 2 (Core)

- Measure
  - >10 percent of medication orders (includes all doses) are tracked from order to administration using eMAR.
- Denominator
  - Medication orders
- Exclusion
  - EH/CAH with average daily census <10 patients

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Electronic Provider Notes

Stage 1

- None

Stage 2 (Menu)

- Measure
  - >30% of unique patients have at least one electronic progress note created, edited and signed by an authorized provider. The text must be text searchable and may contain drawings and other content
- Denominator
  - Unique patients
- Exclusion
  - None

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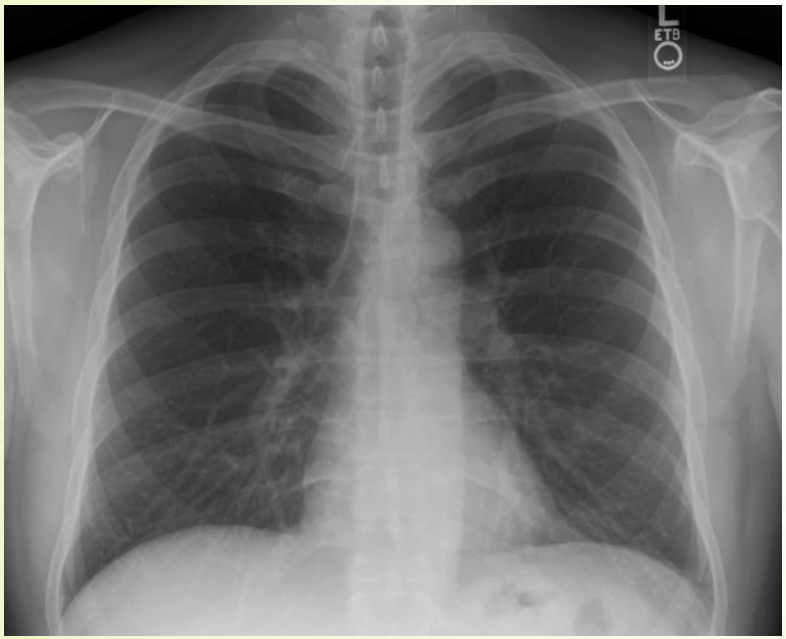
Imaging Results

Stage 1

- None



Stage 2 (Menu)

- Measure
  - >10 percent of all tests whose result is one or more images are accessible through Certified EHR Technology
- Denominator
  - Imaging studies
- Exclusion
  - EP: Orders <100 imaging studies during the EHR reporting period or without access to electronic imaging results at the start of the EHR reporting period.
  - EH: None

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Incorporate Lab Results

Stage 1 (Menu)

- Measure
  - >40% of labs with numeric or +/- result in chart as structured data
- Denominator
  - Unique +/- or numeric lab results
- Exclusion
  - EP: No results of this type ordered
  - EH: None

Stage 2 ***(Core)***

- Measure
  - ***>55%*** of labs with numeric or +/- result in chart as structured data
- Denominator
  - Unique +/- or numeric lab results
- Exclusion
  - EP: No results of this type ordered
  - EH: None

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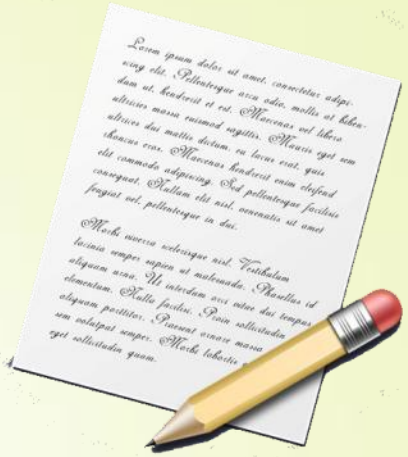
Clinical Summaries (EP)



Stage 1 (Core)

- Measure
  - >50% of office visits, a patient gets a visit summary within 3 business days
- Denominator
  - Office Visits
- Exclusion
  - No office visits during the EHR reporting period

Stage 2 (Core)

- Measure
  - >50% of office visits, a patient ***or their representative*** gets a visit summary within ***1*** business day
- Denominator
  - Office Visits
- Exclusion
  - No office visits during the EHR reporting period

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Clinical Summary Definition:

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

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Electronic Copy of Discharge Instructions (EH)

Stage 1 (Core) for 2013 only

- Measure
  - >50% of patients who request it at discharge
- Denominator
  - Patient requests
- Exclusion
  - No requests

Stage 1 for 2014 and later:

- See “Online Access to Health Information”

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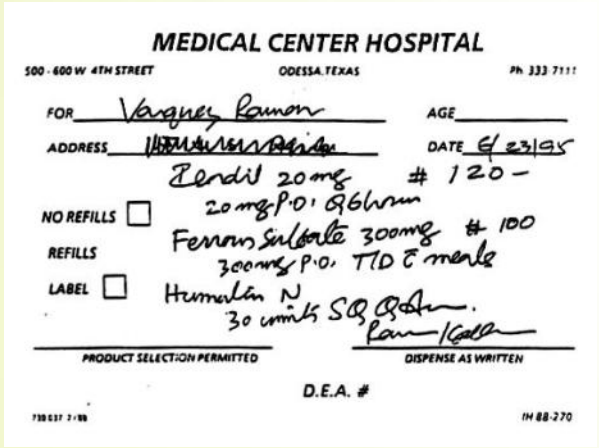
Discharge ePrescribing (EH)

Stage 1

- None



MEDICAL CENTER HOSPITAL

500 - 600 W 4TH STREET ODESSA, TEXAS Ph 333 7111

FOR Vargney Ramon AGE

ADDRESS DATE 6/23/95

Rx Zestril 20 mg # 120 –
20 mg P.O. Q6hrs

NO REFILLS ☐ Ferrous Sulfate 300mg # 100

REFILLS 300mg P.O. TID c meals

LABEL ☐ Humulin N
30 units SQ Q6hrs.

PRODUCT SELECTION PERMITTED DISPENSE AS WRITTEN

D.E.A. #

IH 88-270

Stage 2 (Menu)

- Measure
  - >10 percent of hospital discharge medication orders for permissible prescriptions are queried for a drug formulary and transmitted electronically.
- Denominator
  - Number of new, changed, and refilled prescriptions
- Exclusion
  - No internal pharmacy that can accept electronic prescriptions
  - Not located within 10 miles of any pharmacy that accepts electronic prescriptions

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Transfer of Care / Referral

Stage 1 (Menu)

- Measure
  - >50% of referrals and transitions of care
- Denominator
  - Care transitions
- Exclusion
  - EP: Does not refer or transition
  - EH: None

Stage 2 ***(Core)***

- Measure
  - >50% of referrals and transitions of care
  - ***>10% sent electronically***
  - ***One or more sent electronically to:***
    - ***A different provider with a different EMR***
    - ***The CMS designated test EHR***
- Denominator
  - Care transitions
- Exclusion
  - EP: Does not refer or transition
  - EH: None

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Elements of the Stage 2 Transfer of Care / Referral Summary

- Patient name.
- Referring or transitioning provider's name and office contact information (EP only).
- Demographic information (preferred language, sex, race, ethnicity, date of birth).
- Current problem list (EPs and EHs may also include historical problems at their discretion).
- Current medication list, and
- Current medication allergy list.
- Vital signs (height, weight, blood pressure, BMI).
- Smoking status.
- Immunizations.
- Laboratory test results.
- Procedures.
- Encounter diagnosis
- Functional status, including activities of daily living, cognitive and disability status
- Care plan field, including goals and instructions.
- Care team including the primary care provider of record and any additional known care team members beyond the referring or transitioning provider and the receiving provider.
- Reason for referral (EP)
- Discharge Instructions (EH)

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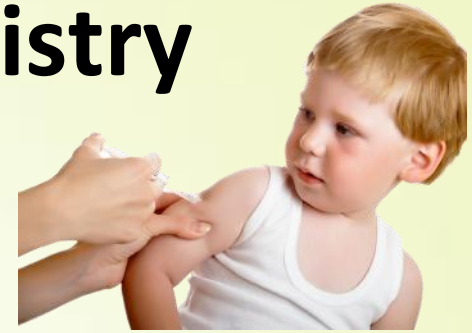
Submit to Immunization Registry



Stage 1 (Menu)

- Measure
  - ≥ 1 test of submission to state immunization registry ***except where prohibited*** with continued submission if successful
- Denominator
  - Yes/No Attest
- Exclusions
  - Administers no immunizations
  - No registry with the capacity to receive

Stage 2 ***(Core)***

- Measure
  - ***Successful ongoing submission*** of electronic immunization data to an immunization registry or information system for the entire EHR reporting period
- Denominator
  - Yes/No Attest
- Exclusion
  - Administers no immunizations
  - No registry with the capacity to receive

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Syndromic Surveillance

Stage 1 (Menu)

- Measure
  - ≥ 1 test of submission to state immunization registry ***except where prohibited*** with continued submission if successful
- Denominator
  - Yes/No Attest
- Exclusions
  - Administers no immunizations
  - No agency with the capacity to receive

Stage 2 (EP: Menu; ***EH: Core***)

- Measure
  - ***Successful ongoing submission*** to a public health agency for the entire EHR reporting period
- Denominator
  - Yes/No Attest
- Exclusion:
  - EP: Not in a category of providers who collect this data
  - EH: No Emergency/Urgent Care
  - No agency with the capacity to receive

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Reportable Labs (EH)

Stage 1 (Menu)

- Measure
  - ≥ 1 test of submission to state immunization registry ***except where prohibited*** with continued submission if successful
- Denominator
  - Yes/No Attest
- Exclusions
  - No agency with the capacity to receive

Stage 2 ***(Core)***

- Measure
  - ***Successful ongoing submission*** to a public health agency for the entire EHR reporting period
- Denominator
  - Yes/No Attest
- Exclusion:
  - No agency with the capacity to receive

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Electronic Copy of Health Information

Stage 1 Core for 2013 only

- Measure
  - >50% of patients who request it (incl: test results, prob list, med list, med allergies and for hospitals: discharge summary and procedures) w/i 3 business days
- Denominator
  - Patient requests
- Exclusion
  - No requests

Stage 1 for 2014 and later:

- See “Online Access to Health Information”

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Timely Electronic Access (EP)

Stage 1 Menu for 2013 only

- Measure
  - >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
- Denominator
  - Unique patients
- Exclusion
  - EP: Neither orders or creates information of this type

Stage 1 for 2014 and later:

- See “Online Access to Health Information”

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Online Access to Health Information

Stage 1 Core for 2014 and later

- Measure
  - ***> 50 percent are provided timely online access to their health information within 4 business days of it being available***
- Denominator
  - Unique patients
- Exclusion
  - EP: Creates no information, except for “Patient name” and “Provider's name” and office contact information.

Stage 2 (Core)

- Measures
  - >50% are provided timely online access to their health information within 4 business days
  - ***>5% view, download, or transmit their health information***
- Denominator
  - Unique patients
- Exclusions
  - EP: Creates no information, except for “Patient name” and “Provider's name” and office contact information, may **exclude both measures**.
  - EP & EH: ≥50% encounters in a county with <50% percent of its housing units have 3Mbps broadband may exclude the **second measure.**

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Protect Personal Health Information

Stage 1 (Core)

- Measure
  - Conduct or review a security risk analysis, implement security updates as necessary and correct identified security deficiencies
- Denominator
  - Yes/No Attest
- Exclusion
  - None

Stage 2 (Core)

- Measure
  - Conduct or review a security risk analysis, ***including the encryption/security of data stored in CEHRT***, implement security updates as necessary and correct identified security deficiencies
- Denominator
  - Yes/No Attest
- Exclusion
  - None

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Patient Lists

Stage 1 (Menu)

- Measure
  - Generate at least one pt list based on a specific condition
- Denominator
  - Yes/No Attest
- Exclusion
  - None

Stage 2 ***(Core)***

- Measure
  - Generate at least one pt list based on a specific condition
- Denominator
  - Yes/No Attest
- Exclusion
  - None

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Patient Reminders (EP)

Stage 1 (Menu)

- Measure
  - >20% of pts ≥ 65 or ≤ 5yo sent reminders for follow up care
- Denominator
  - Unique Patients
- Exclusion
  - No patients ≥ 65 or ≤ 5yo

Stage 2 ***(Core)***

- Measure
  - ***>10% pts with >1 office visit within 2 years*** receive reminders for follow-up care sent per patient preference.
- Denominator
  - ***Unique patients with 2 or more visits in past 24 month***s
- Exclusion
  - No office visits in 24 months before the measurement period

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Secure Electronic Messaging (EP)

Stage 1

- None

Stage 2 (Core)

- Measure
  - >5% of unique patients (or their representatives) seen by the EP during the reporting period send the EP a secure message.
- Denominator
  - Unique patients
- Exclusion
  - No office visits
  - ≥50% encounters in a county with <50% percent of its housing units have 3Mbps broadband

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Provide Electronic Lab Results (EH)

Stage 1

- None

Stage 2 (Menu)

- Measure
  - >20 percent of electronic lab orders received, Hospital labs send structured electronic clinical lab results to the ordering provider
- Denominator
  - Electronic lab orders received
- Exclusion
  - None

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Cancer Registry (EP)

Stage 1

- None

Stage 2 (Menu)

- Measure
  - Successful ongoing submission of cancer case information to a public health central cancer registry for the entire EHR reporting period.
- Denominator
  - Attest yes/no
- Exclusion:
  - EP does not diagnose or directly treat cancer;
  - The EP operates in a jurisdiction for which no public health agency is capable of receiving electronic cancer case information

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Specialized Registries

Stage 1

- None

Stage 2 (Menu)

- Measure
  - Successful ongoing submission of specific case information to a specialized registry for the entire EHR reporting period.
- Denominator
  - Attest yes/no
- Exclusion:
  - EP does not diagnose or directly treat a relevant disease;
  - The EP operates in a jurisdiction for which no public health agency is capable of receiving electronic case information

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Meaningful Use Specification Sheet

- The authoritative source on MU Criteria
- Downloadable PDF index that links to the 2010 Stage 2 Criteria:
  - http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Stage_2.html
- Updated by CMS to account for any corrections or changes
- Includes relevant certification criteria

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Professional Criteria Specification Sheet

http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/Stage2_MeaningfulUseSpecSheet_TableContents_EPs.pdf

Stage 2
Eligible Professional (EP)
Meaningful Use Core and Menu Measures
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Date issued: October, 2012

Eligible Professional Core Objectives	
(1)	Use computerized provider order entry (CPOE) for medication, laboratory and radiology orders directly entered by any licensed healthcare professional who can enter orders into the medical record per state, local and professional guidelines.
(2)	Generate and transmit permissible prescriptions electronically (eRx).
(3)	Record the following demographics: preferred language, sex, race, ethnicity, date of birth.
(4)	Record and chart changes in the following vital signs: height/length and weight (no age limit); blood pressure (ages 3 and over); calculate and display body mass index (BMI); and plot and display growth charts for patients 0-20 years, including BMI.
(5)	Record smoking status for patients 13 years old or older.
(6)	Use clinical decision support to improve performance on high-priority health conditions.
(7)	Provide patients the ability to view online, download and transmit their health information within four business days of the information being available to the EP.
(8)	Provide clinical summaries for patients for each office visit.
(9)	Protect electronic health information created or maintained by the Certified EHR Technology through the implementation of appropriate technical capabilities.
(10)	Incorporate clinical lab-test results into Certified EHR Technology as structured data.

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Example of Clinical Summaries Measure

Stage 2
Eligible Professional
Meaningful Use Core Measures
Measure 15 of 17

Date issued: November, 2012

Summary of Care	
Objective	The EP who transitions their patient to another setting of care or provider of care or refers their patient to another provider of care should provide summary care record for each transition of care or referral.
Measures	EPs must satisfy both of the following measures in order to meet the objective: Measure 1: • The EP who transitions or refers their patient to another setting of care or provider of care provides a summary of care record for more than 50 percent of transitions of care and referrals. Measure 2: • The EP who transitions or refers their patient to another setting of care or provider of care provides a summary of care record for more than 10 percent of such transitions and referrals either (a) electronically transmitted using CEHRT to a recipient or (b) where the recipient receives the summary of care record via exchange facilitated by an organization that is a NwHIN Exchange participant or in a manner that is consistent with the governance mechanism ONC establishes for the NwHIN. Measure 3: An EP must satisfy one of the following criteria: • Conducts one or more successful electronic exchanges of a summary of care document, as part of which is counted in "measure 2" (for EPs the measure at §495.6(j)(14)(ii)(B) with a recipient who has EHR technology that was developed designed by a different EHR technology developer than the sender's EHR technology certified to 45 CFR 170.314(b)(2). • Conducts one or more successful tests with the CMS designated test EHR during the EHR reporting period.
Exclusion	Any EP who transfers a patient to another setting or refers a patient to another provider less than 100 times during the EHR reporting period is excluded from all three measures.

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Definition of Terms

Transition of Care – The movement of a patient from one setting of care (hospital, ambulatory primary care practice, ambulatory, specialty care practice, long-term care, home health, rehabilitation facility) to another. At a minimum this includes all transitions of care and referrals that are ordered by the EP.

Summary of Care Record – A summary of care record must include the following elements:

- Patient name.
- Referring or transitioning provider's name and office contact information (EP only).
- Procedures.
- Encounter diagnosis
- Immunizations.
- Laboratory test results.
- Vital signs (height, weight, blood pressure, BMI).
- Smoking status.
- Functional status, including activities of daily living, cognitive and disability status
- Demographic information (preferred language, sex, race, ethnicity, date of birth).
- Care plan field, including goals and instructions.
- Care team including the primary care provider of record and any additional known care team members beyond the referring or transitioning provider and the receiving provider.
- Reason for referral
- Current problem list (EPs may also include historical problems at their discretion).
- Current medication list, and
- Current medication allergy list.

Problem List – At a minimum a list of current, active and historical diagnoses. We do not limit the EP to just including diagnoses on the problem list.

Active/current medication list – A list of medications that a given patient is currently taking.

Active/current medication allergy list – A list of medications to which a given patient has known allergies.

Allergy – An exaggerated immune response or reaction to substances that are generally not harmful.

Care Plan – The structure used to define the management actions for the various conditions, problems, or issues. A care plan must include at a minimum the following components: problem (the focus of the care plan), goal (the target outcome) and any instructions that the provider has given to the patient. A goal is a defined target or measure to be achieved in the process of patient care (an expected outcome).

Attestation Requirements

DENOMINATOR/NUMERATOR/ THRESHOLD/EXCLUSION

MEASURE 1:

- DENOMINATOR: Number of transitions of care and referrals during the EHR reporting period for which the EP was the transferring or referring provider.
- NUMERATOR: The number of transitions of care and referrals in the denominator where a summary of care record was provided.
- THRESHOLD: The percentage must be more than 50 percent in order for an EP to meet this measure.

Example of Clinical Summaries Measure

- EXLCUSION: Any EP who transfers a patient to another setting or refers a patient to another provider less than 100 times during the EHR reporting period is excluded from all three measures.

MEASURE 2:

- DENOMINATOR: Number of transitions of care and referrals during the EHR reporting period for which the EP was the transferring or referring provider.
- NUMERATOR: The number of transitions of care and referrals in the denominator where a summary of care record was a) electronically transmitted using CEHRT to a recipient or b) where the recipient receives the summary of care record via exchange facilitated by an organization that is a NwHIN Exchange participant or in a manner that is consistent with the governance mechanism ONC establishes for the nationwide health information network. The organization can be a third-party or the sender's own organization.
- THRESHOLD: The percentage must be more than 10 percent in order for an EP to meet this measure.
- EXCLUSION: Any EP who transfers a patient to another setting or refers a patient to another provider less than 100 times during the EHR reporting period is excluded from all three measures.

MEASURE 3:

YES/NO

The EP attests YES to one of the two criteria:

1. Conducts one or more successful electronic exchanges of a summary of care document, as part of which is counted in "measure 2" (for EPs the measure at §495.6(j)(14)(ii)(B) with a recipient who has EHR technology that was developed designed by a different EHR technology developer than the sender's EHR technology certified to 45 CFR 170.314(b)(2).

   or

2. Conducts one or more successful tests with the CMS designated test EHR during the EHR reporting period.

- EXCLUSION: Any EP who transfers a patient to another setting or refers a patient to another provider less than 100 times during the EHR reporting period is excluded from all three measures.

Additional Information

- Only patients whose records are maintained using certified EHR technology must be included in the denominator for transitions of care.
- The EP that transfers or refers the patient to another setting of care or provider should provide the summary of care document. It is for this provider that has the most recent information on the patient that may be crucial to the provider to whom the patient is transferred or referred.
- The EP can send an electronic or paper copy of the summary care record directly to the next provider or can provide it to the patient to deliver to the next provider, if the patient can reasonably expected to do so and meet Measure 1.

- If the provider to whom the referral is made or to whom the patient is transitioned to has access to the medical record maintained by the referring provider then the summary of care record would not need to be provided, and that patient must not be included in the denominator for transitions of care.
- To count in the numerator of any measure, the EP must verify these three fields for current problem list, current medication list, and current medication allergy list are not blank and include the most recent information known by the EP or hospital as of the time of generating the summary of care document.
- To count in the numerator of measure 2, the summary of care record must be received by the provider to whom the sending provider is referring or transferring the patient.
- To count in the numerator of measure 2, one of the following three transmission approaches must be used:
  - Use of the transport standard capability required for certification. As required by ONC to meet the CEHRT definition, every EP, eligible hospital, and CAH, must have EHR technology that is capable of electronically transmitting a summary care record for transitions of care and referrals according to the primary Direct Project specification (the Applicability Statement for Secure Health Transport). Thus, EPs, eligible hospitals, or CAHs that electronically transmit summary care records using their CEHRT's "Direct" capability (natively or combined with an intermediary) would be able to count all such electronic transmissions in their numerator.
  - Use of the SOAP-based optional transport standard capability permitted for certification. As part of certification, ONC permits EHR technology developers to voluntarily seek certification for their EHR technology's capability to perform SOAP-based electronic transmissions. EHR technology developers who take this approach would enable their customers to also use this approach to meet the measure. Thus, EPs, eligible hospitals, or CAHs that electronically transmit summary care records using their CEHRT's "SOAP-based" capability (natively or combined with an intermediary) would be able to count all of those transmissions in their numerator.
  - Use of CEHRT to create a summary care record in accordance with the required standard (i.e., Consolidated CDA as specified in 45 CFR 170.314(b)(2)), and the electronic transmission is accomplished through the use of an eHealth Exchange participant who enables the electronic transmission of the summary care record to its intended recipient. Thus, EPs, eligible hospitals, or CAHs who create standardized summary care records using their CEHRT and then use an eHealth Exchange participant to electronically transmit the summary care record would be able to count all of those transmissions in their numerator. See related FAQ.
- In order to meet this objective and measure, an EP must use the capabilities and standards of CEHRT at 45 CFR 170.314(b)(1), (b)(2), (g)(1), and (g)(2).

Example of Clinical Summaries Measure

Certification and Standards Criteria

Below is the corresponding certification and standards criteria for electronic health record technology that supports achieving the meaningful use of this objective.

Certification Criteria	
§ 170.314 (b) (1) Transitions of care receive, display, and incorporate transition of care/referral summaries	(i) Receive. EHR technology must be able to electronically receive transition of care/referral summaries in accordance with: A. The standard specified in § 170.202(a). B. Optional. The standards specified in § 170.202(a) and (b). C. Optional. The standards specified in § 170.202(b) and (c). (ii) Display. EHR technology must be able to electronically display in human readable format the data included in transition of care/referral summaries received and formatted according to any of the following standards (and applicable implementation specifications) specified in: § 170.205(a)(1), § 170.205(a)(2), and § 170.205(a)(3). (iii) Incorporate. Upon receipt of a transition of care/referral summary formatted according to the standard adopted at § 170.205(a)(3), EHR technology must be able to: A. Correct patient. Demonstrate that the transition of care/referral summary received is or can be properly matched to the correct patient. B. Data incorporation. Electronically incorporate the following data expressed according to the specified standard(s): ▪ Medications. At a minimum, the version of the standard specified in § 170.207(d)(2); ▪ Problems. At a minimum, the version of the standard specified in § 170.207(a)(3); ▪ Medication allergies. At a minimum, the version of the standard specified in § 170.207(d)(2). ▪ Section views. Extract and allow for individual display each additional section or sections (and the accompanying document header information) that were included in a transition of care/referral summary received and formatted in accordance with the standard adopted at § 170.205(a)(3).
§ 170.314(b)(2) Transitions of care create and transmit transition of care/referral summaries	(i) Create. Enable a user to electronically create a transition of care/referral summary formatted according to the standard adopted at § 170.205(a)(3) that includes, at a minimum, the Common MU Data Set and the following data expressed, where applicable, according to the specified standard(s): A. Encounter diagnoses. The standard specified in § 170.207(i) or, at a minimum, the version of the standard specified § 170.207(a)(3); B. Immunizations. The standard specified in § 170.207(e)(2); C. Cognitive status; D. Functional status; and E. The reason for referral; and referring or transitioning provider's name and office contact information. (ii) Transmit. Enable a user to electronically transmit the transition of care/referral summary created in paragraph (b)(2)(i) of this section in accordance with:

	A. The standard specified in § 170.202(a). B. Optional. The standards specified in § 170.202(a) and (b). C. Optional. The standards specified in § 170.202(b) and (c).

**Depending on the type of certification issued to the EHR technology, it will also have been certified to the certification criterion adopted at 45 CFR 170.314 (g)(1), (g)(2), or both, in order to assist in the calculation of this meaningful use measure.*

Standards Criteria	
§ 170.202(a) Transport standards	ONC Applicability Statement for Secure Health Transport (incorporated by reference in § 170.299).
§ 170.202(b) Transport standards	ONC XDR and XDM for Direct Messaging Specification (incorporated by reference in § 170.299).
§ 170.202(c) Transport standards	ONC Transport and Security Specification (incorporated by reference in § 170.299).
§ 170.205(a)(1) Patient summary records	(i) Standard. Health Level Seven Clinical Document Architecture (CDA) Release 2, Level 2 Continuity of Care Document (CCD) (incorporated by reference in §170.299). (ii) Alternative standard. ASTM E2369 Standard Specification for Continuity of Care Record and Adjunct to ASTM E2369 (incorporated by reference in §170.299).
§ 170.205(a)(2) Problem list	(i) Standard. The code set specified for the conditions specified at 45 CFR 162.1002(a)(1). (ii) Alternative standard. International Health Terminology Standards Development Organization (IHTSDO) Systematized Nomenclature of Medicine Clinical Terms (SNOMED CT®) July 2009 version (incorporated by reference in §170.299).
§ 170.205(a)(3)	HL7 Implementation Guide for CDA® Release 2: IHE Health Story Consolidation, (incorporated by reference in § 170.299). The use of the "unstructured document" document level template is prohibited.
§ 170.207(d)(2) Medications	RxNorm, a standardized nomenclature for clinical drugs produced by the United States National Library of Medicine, August 6, 2012 Release (incorporated by reference in § 170.299).
§ 170.207(a)(3)	IHTSDO SNOMED CT® International Release July 2012 (incorporated by reference in § 170.299) and US Extension to SNOMED CT® March 2012 Release (incorporated by reference in § 170.299).
§ 170.207(i) Encounter diagnoses	The code set specified at 45 CFR 162.1002(c)(2) for the indicated conditions.
§ 170.207(e)(2) Immunizations	HL7 Standard Code Set CVX -- Vaccines Administered, updates through July 11, 2012 (incorporated by reference in § 170.299).

Stage 1 Criteria for 2014:

Core:

Numerator/Denominator:

- Demographics
- Problem list
- Medication list
- Medication allergy list
- CPOE
- E-Prescribing (EP only)
- Vital signs
- Smoking status
- Clinical summaries (EP Only)

On (Yes or No):

- Drug (D-A, D-D) Interactions
- One clinical decision support rule
- Provide patients with eAccess
- Protect electronic health information

Menu:

Numerator/Denominator:

- Provide patient-specific education resources
- Advanced directives (EH only)
- Labs as structured data
- Patient reminders (EP only)
- Medication reconciliation
- Referral/Transfer of care summary

On (Yes or No):

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

* At least 1 public health objective must be selected

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Stage 2 Criteria for 2014:

Core:

Numerator/Denominator:

- Demographics
- Medication reconciliation
- CPOE
- E-Prescribing (EP only)
- Electronic medication administration (EH Only)
- Vital signs
- Smoking status
- Clinical summaries (EP Only)
- Labs as structured data
- Provide patient-specific education resources
- Referral/Transfer of care summary
- Patient reminders (EP only)
- Secure messages from patients (EP Only)

Yes or No:

- Patient list by specific condition
- 5 clinical decision support rules (with D-D, D-A)
- Provide patients with eAccess with some using it
- Submission of electronic data to immunization registries.
- Submission of reportable labs to public health. (EH only)
- Protect electronic health information
- Provide electronic syndromic surveillance data to public health agencies. (EH Only)

Menu:

Numerator/Denominator:

- Advanced directives (EH only)
- Electronic notes
- Imaging results
- Family health history
- Report to cancer registries (EP Only)
- Report to specialized registries (EP Only)
- E-Prescribing (EH only)
- Return lab results electronically (EH only)

Yes or No:

- Provide electronic syndromic surveillance data to public health agencies. (EP Only)

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Small Group Exercise

Clinics

- Devise a plan for gathering the necessary information to complete either of the following in as required by the measure
  - Clinical (after visit) Summary
  - Referral/Transfer of Care

Hospitals

- Some measures require active “buy-in” by hospital staff. Devise a plan to help meet one of the following measures:
  - CPOE
  - eMAR with med tracking
  - Electronic notes

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Meaningful Use Outline

- A reminder of why we are doing this
- Changes to the timeline
- Reminder of the incentives
- Clarification of the Medicare penalties
- New EHR software certification standards for 2014
- New and revised functional criteria requirements for Stages 1 & 2
- **New quality measurement requirements starting in 2014**
- What you need to do now

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Changes to CQMs Reporting

Prior to 2014		Beginning in 2014	
EPs	Report 6 out of 44 CQMs • 3 core or alt. core • 3 menu	EPs	Report 9 out of 64 CQMs Selected CQMs must cover at least 3 of the 6 NQS domains Recommended core CQMs: • 9 for adult populations • 9 for pediatric Populations
Eligible Hospitals and CAHs	Report 15 out of 15 CQMs	Eligible Hospitals and CAHs	Report 16 out of 29 CQMs Selected CQMs must cover at least 3 of the 6 NQS domains

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CQM Specifications

- No change in specifications for the CQMs in 2013
- For EPs starting in 2014
  - 32 of the 44 CQMs finalized in the Stage 1 final rule will remain
  - 32 new CQMs will be added totalling 64
- For EHs / CAHs
  - All 15 of the CQMs finalized in the Stage 1 final rule plus 14 new CQMs totaling 29
- Case Thresholds for EHs/CAHs

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Case Thresholds for Hospital CQM Exemptions, 2014 and later

- For EHs/CAHs in their first year of Meaningful use
  - No change regardless of year – attest to the numbers
- For EHs/CAHs in 2014 *only*:
  - If 5 or fewer discharges per quarter, measure may be exempted
  - Must still submit aggregate and sample size counts for the quarter CQM reporting period
- For EHs/CAHs in 2015 and after:
  - If 20 or fewer discharges per full fiscal year reporting period, measure may be exempted
  - Must still submit aggregate and sample size counts for the fiscal year CQM reporting period

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2013 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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2013 Optional EP 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%)~~*

* Greyed and struck through items (~~example~~) were either revised or discontinued for 2014

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2013 Optional EP 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

* Greyed and struck through items (~~example~~) were either revised or discontinued for 2014

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2013 Optional EP Quality Measures – Prevention

- 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~~*

* Greyed and struck through items (~~example~~) were either revised or discontinued for 2014

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2013 Optional EP 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

* Greyed and struck through items (~~example~~) were either revised or discontinued for 2014

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2013 Optional EP Quality Measures

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

* Greyed and struck through items (~~example~~) were either revised or discontinued for 2014

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CQM Selection for 2014

- All EPs must select 9 and EHs/CAHs 16 CQMs from at least 3 of the 6 HHS National Quality Strategy domains:
  - Patient and Family Engagement
  - Patient Safety
  - Care Coordination
  - Population and Public Health
  - Efficient Use of Healthcare Resources
  - Clinical Processes/Effectiveness

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2014 New EP Quality Measures – Depression

- Bipolar disorder and major depression: Appraisal for alcohol or chemical substance use
- Child and adolescent major depressive disorder: suicide risk assessment
- Depression remission at twelve months
- Depression utilization of the PHQ-9 tool
- Major depressive disorder (MDD): suicide risk assessment
- Maternal depression screening

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2014 New EP Quality Measures

- Pediatrics.
  - Appropriate treatment for children with upper respiratory infection (URI)
  - ADHD: Follow-up care for children prescribed attention-deficit/hyperactivity disorder (ADHD) medication
  - Children who have dental decay or cavities
  - Hemoglobin A1c test for pediatric patients
- Geriatrics
  - Dementia: cognitive assessment
  - Falls: screening for future fall risk
  - Use of high-risk medications in the elderly

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2014 New EP Quality Measures

- HIV/AIDS
  - Medical Visit
  - Pneumocystis jiroveci pneumonia (PCP) Prophylaxis
  - RNA control for Patients with HIV
- Cataracts:
  - Complications within 30 Days Following Cataract Surgery Requiring Additional Surgical Procedures
  - 20/40 or Better Visual Acuity within 90 Days Following Cataract Surgery

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2014 New EP Quality Measures

- Functional Status Assessment
  - For complex chronic conditions
  - Hip replacement
  - Knee replacement
- Preventive Care and Screening:
  - Cholesterol—Fasting Low Density Lipoprotein (LDL-C) Test Performed
  - Risk-Stratified Cholesterol—Fasting Low Density Lipoprotein (LDL-C)
  - Screening for Clinical Depression and Follow-Up Plan
  - Screening for High Blood Pressure and Follow-Up Documented
  - Primary Caries Prevention Intervention as Offered by Primary Care Providers, including Dentists

2014 New EP Quality Measures

- Pregnancy
  - Pregnant women that had HBsAg testing
- Oncology
  - Medical and Radiation—Pain Intensity Quantified
- ADE Prevention and Monitoring
  - Warfarin Time in Therapeutic Range
- Closing the referral loop
  - Receipt of specialist report
- Medication Management
  - Documentation of Current Medications in the Medical Record
- Hypertension
  - Improvement in blood pressure

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2014 CQMs Recommended for Adults

Patient and Family Engagement.	Functional status assessment for complex chronic conditions
Patient Safety.	Use of High-Risk Medications in the Elderly
	Documentation of Current Medications in the Medical Record Description
Care Coordination.	Closing the referral loop: receipt of specialist report
Population/Public Health.	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention
	Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up
	Preventive Care and Screening: Screening for Clinical Depressionand Follow-Up Plan
Efficient Use of Healthcare Resources.	Use of Imaging Studies for Low Back Pain
Clinical Process/Effectiveness.	Controlling High Blood Pressure

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2014 CQMs Recommended for Children

Population/Public Health.	Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents
	Chlamydia Screening for Women
	Childhood Immunization Status
	Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan
Efficient Use of Healthcare Resources.	Appropriate Testing for Children with Pharyngitis
	Appropriate Treatment for Children with Upper Respiratory Infection (URI)
Clinical Process/Effectiveness.	Use of Appropriate Medications for Asthma
	ADHD: Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication
	Children who have dental decay or cavities Description: Percentage of children ages 0-20, who have had tooth decay or cavities during the measurement period.

2014 Hospital Quality Measures
15 Old Measures:

- **ED Throughput**
  - Admitted patients: Median time from ED arrival to ED departure for admitted patients
  - Admitted patients: Admission decision time to ED departure time for admitted patients
- **Ischemic Stroke**
  - Discharge on antithrombotics
  - Anticoagulation for A-fib/flutter
  - Thrombolytic therapy for patients arriving within 2 hours of symptom onset
  - Discharge on statins
- **Ischemic or Hemorrhagic Stroke:**
  - Antithrombotic therapy by day 2
  - Stroke education
  - Rehabilitation assessment
- **Venous Thromboembolism:**
  - Prophylaxis within 24 hours of arrival
  - Intensive Care Unit prophylaxis
  - Anticoagulation overlap therapy
  - Platelet monitoring on unfractionated heparin
  - VTE discharge instructions
  - Incidence of potentially preventable VTE

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2014 Hospital Quality Measures
14 New Measures

- **ED Throughput**
  - Median time from ED arrival to ED departure for discharged ED patients
- **AMI measures**
  - Aspirin Prescribed at Discharge for AMI
  - Fibrinolytic Therapy Received Within 30 minutes of Hospital Arrival
  - Primary PCI Received Within 90 Minutes of Hospital Arrival
  - Statin Prescribed at Discharge
- **Pediatric**
  - Elective Delivery Prior to 39 Completed Weeks Gestation
  - Healthy Term Newborn
  - Hearing screening prior to hospital discharge
  - Exclusive Breast Milk Feeding
- **Surgical Care**
  - Prophylactic Antibiotic Received within 1 Hour Prior to Surgical Incision
  - Prophylactic Antibiotic Selection for Surgical Patients
  - Urinary catheter removed on Postoperative Day 1 or 2
- **Home Management Plan of Care**
  - Home Management Plan of Care (HMPC) Document Given to Patient/Caregiver
- **Pneumonia**
  - Initial Antibiotic Selection for Community-Acquired Pneumonia (CAP) in Immunocompetent Patients

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CQM Reporting in 2013

- CQM reporting will remain the same through 2013.
- In 2013, there are two reporting methods available for reporting the Stage 1 measures:
  - Attestation
  - eReporting pilots
    - Physician Quality Reporting System EHR Incentive Program Pilot for EPs
    - eReporting Pilot for eligible hospitals and CAHs
  - Medicaid providers submit CQMs according to their state-based submission requirements.

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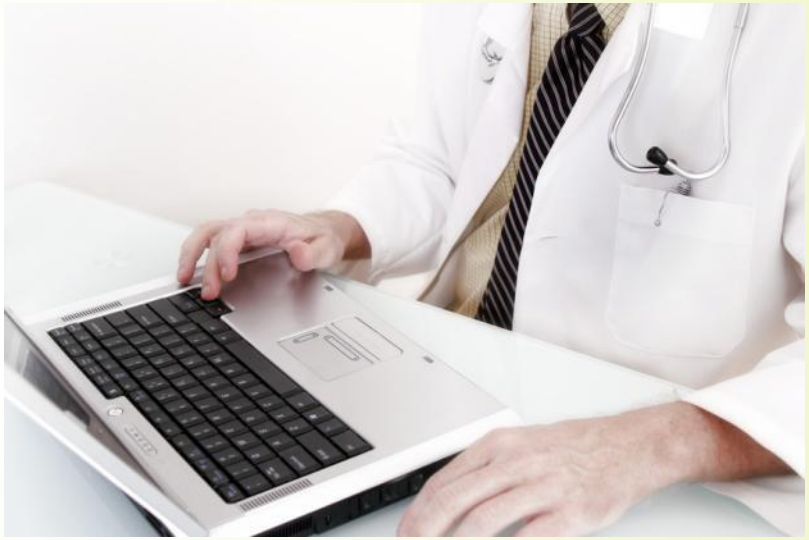
Electronic Submission of CQMs Beginning in 2014

- Beginning in 2014, all Medicare-eligible providers in their second year and beyond of meaningful use must electronically report their CQM data to CMS.
- Medicaid providers will report their CQM data to their state, which may include electronic reporting.



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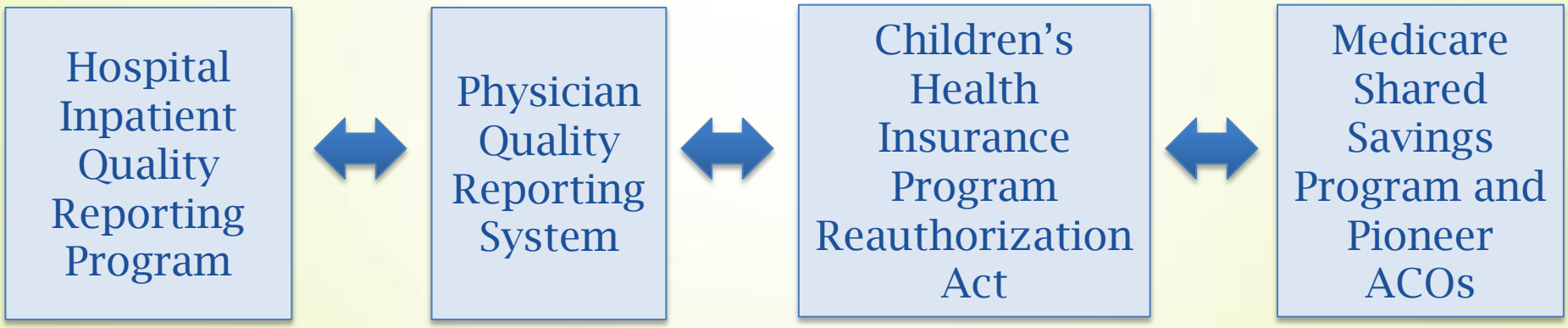
Aligning CQMs Across Programs

- The same CQMs will be used in multiple quality reporting programs beginning in 2014
  - Other programs include Hospital IQR Program, PQRS, CHIPRA, and Medicare SSP and Pioneer ACOs



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EP CQM Reporting Beginning in 2014

Eligible Professionals reporting for the Medicare EHR Incentive Program

Category	Data Level	Payer Level	Submission Type	Reporting Schema
First Year of Demonstrating MU*	Aggregate	All payer	Attestation	Submit 9 CQMs from EP measures table (includes adult and pediatric recommended core CQMs), covering at least 3 domains
EPs Beyond the 1st Year of Demonstrating Meaningful Use				
Option 1	Aggregate	All payer	Electronic	Submit 9 CQMs from EP measures table (includes adult and pediatric recommended core CQMs), covering at least 3 domains
Option 2	Patient	Medicare	Electronic	Satisfy requirements of PQRS EHR Reporting Option using CEHRT
Group Reporting (only EPs Beyond the 1st Year of Demonstrating Meaningful Use)**				
EPs in an ACO (Medicare Shared Savings Program or Pioneer ACOs)	Patient	Medicare	Electronic	Satisfy requirements of Medicare Shared Savings Program or Pioneer ACOs using CEHRT
EPs satisfactorily reporting via PQRS group reporting options	Patient	Medicare	Electronic	Satisfy requirements of PQRS group reporting options using CEHRT

**Attestation is required for EPs in their 1st year of demonstrating MU because it is the only reporting method that would allow them to meet the submission deadline of October 1 to avoid a payment adjustment.*

***Groups with EPs in their 1st year of demonstrating MU can report as a group, however the individual EP(s) who are in their 1st year must attest to their CQM results by October 1 to avoid a payment adjustment.*

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Hospital CQM Reporting Beginning in 2014

Eligible Hospitals reporting for the Medicare EHR Incentive Program

Category	Data Level	Payer Level	Submission Type	Reporting Schema
First Year of Demonstrating MU*	Aggregate	All payer	Attestation	Submit 16 CQMs from Eligible Hospital/CAH measures table, covering at least 3 domains
Eligible Hospitals/CAHs Beyond the 1st Year of Demonstrating Meaningful Use				
Option 1	Aggregate	All payer	Electronic	Submit 16 CQMs from Eligible Hospital/CAH measures table, covering at least 3 domains
Option 2	Patient	All payer (sample)	Electronic	Submit 16 CQMs from Eligible Hospital/CAH measures table, covering at least 3 domains ➢ Manner similar to the 2012 Medicare EHR Incentive Program Electronic Reporting Pilot

**Attestation is required for Eligible Hospitals in their first year of demonstrating MU because it is the only reporting method that would allow them to meet the submission deadline of July 1 to avoid a payment adjustment.*

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2014 CQM Quarterly Reporting

- For Medicare providers, beyond their first attestation year, the 2014 3-month reporting period is fixed to the quarter of either the fiscal or calendar year in order to align with existing CMS quality reporting programs.
- In subsequent years, the reporting period for CQMs would be the entire calendar year (for EPs) or fiscal year (for eligible hospitals and CAHs) for providers beyond the 1st year of MU.

Provider Type	Optional Reporting Period in 2014	Reporting Period for Subsequent Years of Meaningful Use	Submission Period for Subsequent Years of Meaningful Use
EP	Calendar year quarter: January 1 – March 31 April 1 – June 30 July 1 – September 30 October 1 – December 31	1 calendar year (January 1 - December 31)	2 months following the end of the reporting period (January 1 - February 28)
Eligible Hospital/CAH	Fiscal year quarter: October 1 – December 31 January 1 – March 31 April 1 – June 30 July 1 – September 30	1 fiscal year (October 1 - September 30)	2 months following the end of the reporting period (October 1 - November 30)

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Small Group Exercise

At your table, prioritize the items your facility needs to start thinking about now to be ready for 2014

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Meaningful Use Outline

- A reminder of why we are doing this
- Changes to the timeline
- Reminder of the incentives
- Clarification of the Medicare penalties
- New EHR software certification standards for 2014
- New and revised functional criteria requirements for Stages 1 & 2
- New quality measurement requirements starting in 2014
- **What you need to do now**

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What you can do to prepare

- Prepare for sharing information with patients:
  - Complete patients' problem, medication and allergy lists. Make sure they are up to date and current
  - Decide what types of information you will share with patients
    - Patient portals will require a lot of decision making on the part of providers
  - Begin to encourage patients to get involved in their care
    - Talk up the fact that you will be adding technology to allow them to make appointments on line, message their provider and get their lab results
    - Help patients identify where they might access a computer (library, waiting room) and how to manage privacy in such a setting
  - Explore whether you will use your vendor's portal solution or some other option
- Prepare for exchanging information with others:
  - Establish relationships with other organizations to which you refer in order to begin planning exchange (be sure to include nursing homes and home care)
  - Think about a connecting with your cancer registry or some other national registry to submit data

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What you can do to prepare

- Make sure your technology will be ready
  - Plan to undergo an EHR upgrade in late 2013 early 2014
  - Talk with your vendor about upgrade timelines
  - Look at the quality measures and let your vendor know which ones are important to you
  - For hospitals, prepare for bar-coded medication administration
- Plan for more decision support
  - Understand how your vendor will support having 5 “interventions” tied to relevant quality measures
  - Begin to think about the types of interventions you will incorporate into your EHR
- Remember that we are doing this to achieve the “Triple Aim” of health care:
  - Improving the patient experience of care (including quality and satisfaction)
  - Improving the health of populations
  - Reducing the per capita cost of health care

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Resources:

- These Boot Camp Materials:
  - http://khaREACH.org/bc/
- Regional Extension Assistance Center for Health Information Technology (REACH)
  - http://www.khaREACH.org
- Stratis Health HIT Toolkits for hospitals, clinics, home health, nursing homes and chiropractic
  - http://www.stratishealth.org/expertise/healthit/
- Minnesota Department of Health Info Sheet on Public Reporting Measures:
  - http://www.health.state.mn.us/e-health/phreportmu.pdf
- CMS Stage 1 web tip sheet (from the Stage 2 web page):
  - http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/Stage1ChangesTipsheet.pdf
- CMS Stage 2 web page (with Stage 2 specification sheets)
  - http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Stage_2.html
- CMS Meaningful Use Site:
  - http://www.cms.gov/EHRIncentivePrograms/
  - Caution: Stage 1 information and spec sheets on the main meaningful use page have not been updated as of 1/5/13)
- Office of the National Coordinator Health IT site:
  - http://HealthIT.gov (As of 1/5/13, not yet updated for 2013 Stage 1 or Stage 2)
- Certified EHRs and what modules they are certified for:
  - http://healthit.hhs.gov/chpl
- CMS Stage 3 request for comment
  - http://www.healthit.gov/buzz-blog/meaningful-use/set-stage-meaningful-stage-3

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