Understanding the Stage 1 EHR Incentive Final Rule

Key Health Alliance

Regional Extension Assistance Center for HIT

Meaningful Use Mini Boot Camp

April 11, 2012

Introductions

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

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Objectives

- Understand the driving force behind the transformation of Health Care
- Identify the criteria and quality measures that will need to be reported to be a "meaningful user"
- Understand how achieving these will impact workflow
- Become familiar with methods for engaging physicians

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Outline

- **Background to the Final Rule**
- Financial Incentives
  - For Professionals
  - For Hospitals
- Elements of Meaningful Use
- Quality Measures
  - For Professionals
  - For Hospitals
- Proposed Stage II Criteria
- Physician Engagement
- Closure

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The History:
National Academies Reports

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

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

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

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

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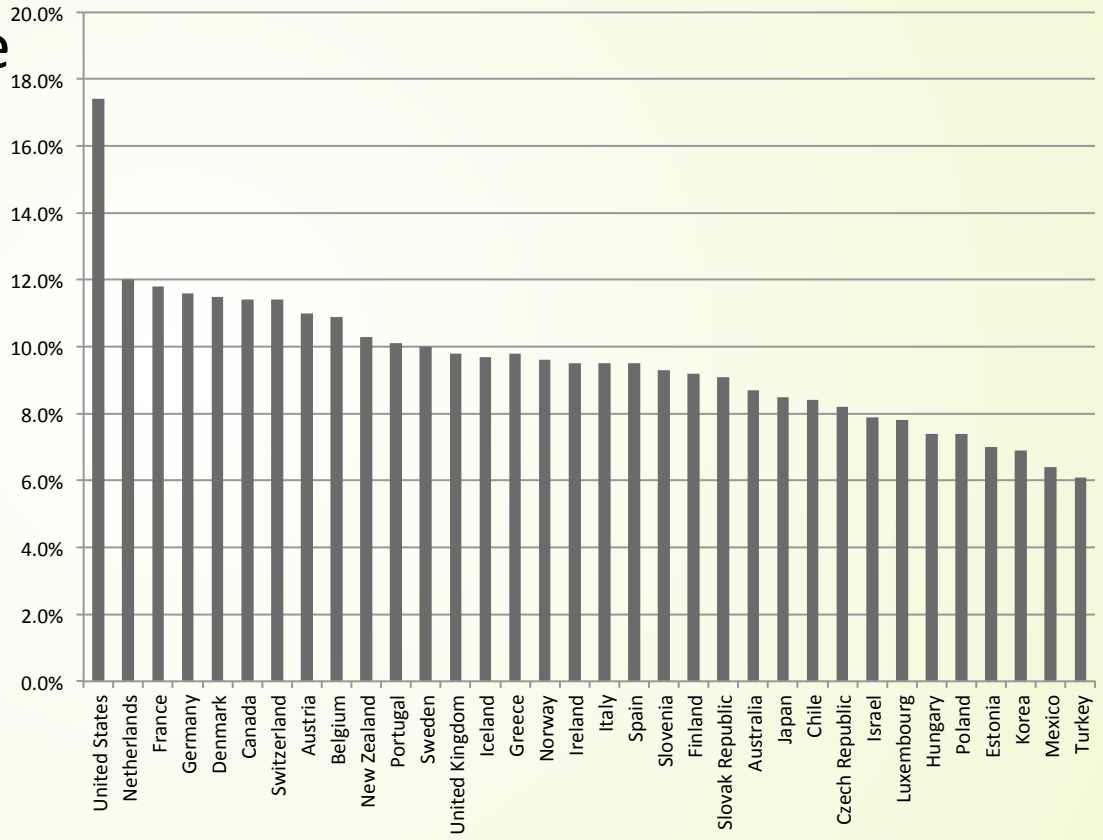
Are we getting value for our dollar? Cost vs. Quality

- Per capita health care spending
  - $2.6T (2010)[1]
  - 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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Underinvestment in HIT

Per Capita Spending on Health Information Technology

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

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Patients Want More Accessible, Coordinated, Well-Informed Care

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

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

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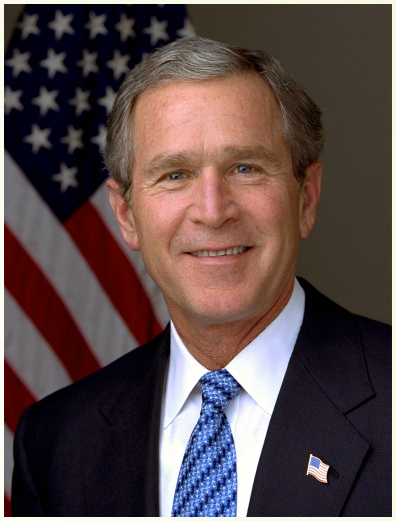
The Bi-Partisan Support:

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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The Stimulus

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

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Meaningful Use Overview: Statutory Framework

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

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

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

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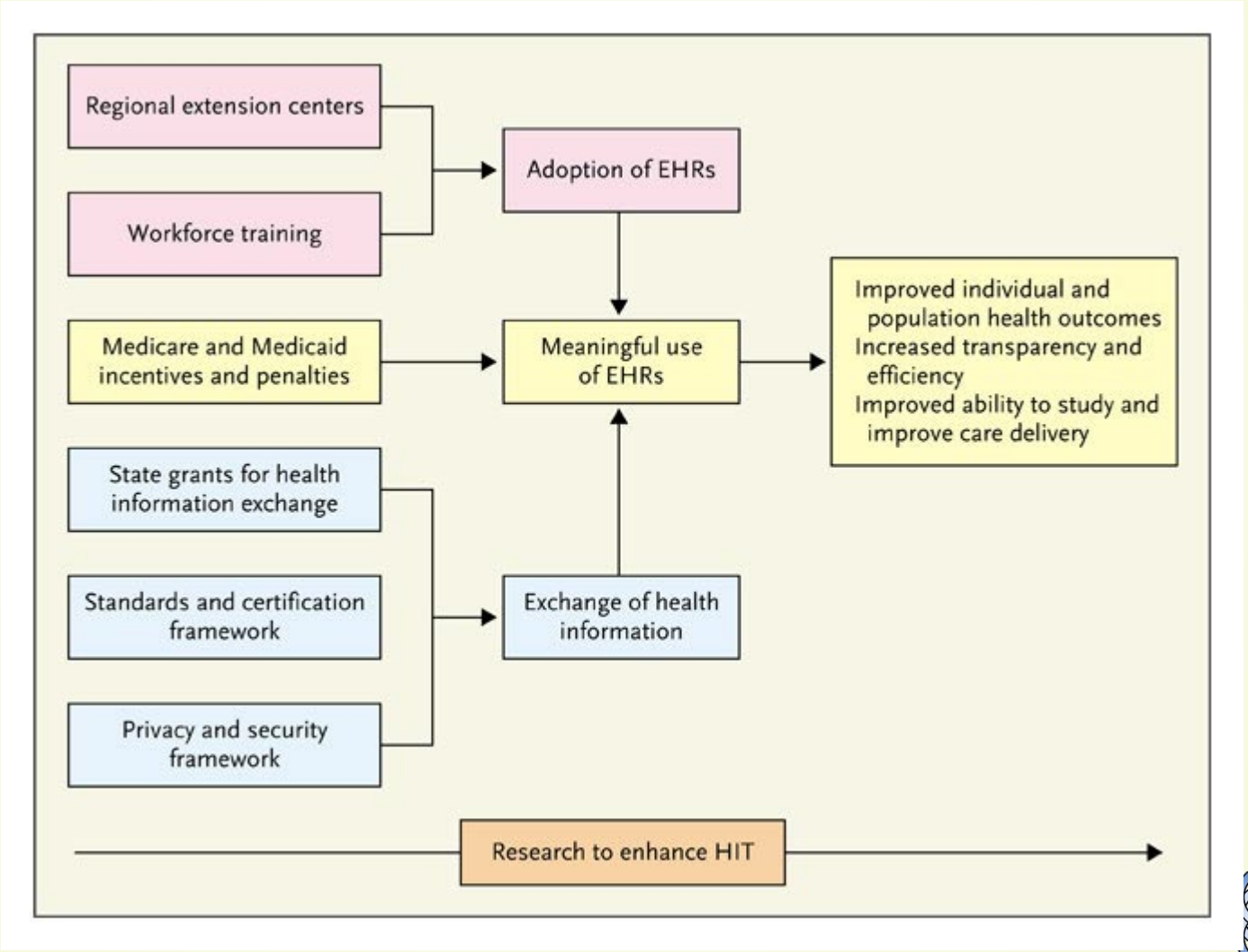
The HITECH Act's Framework



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

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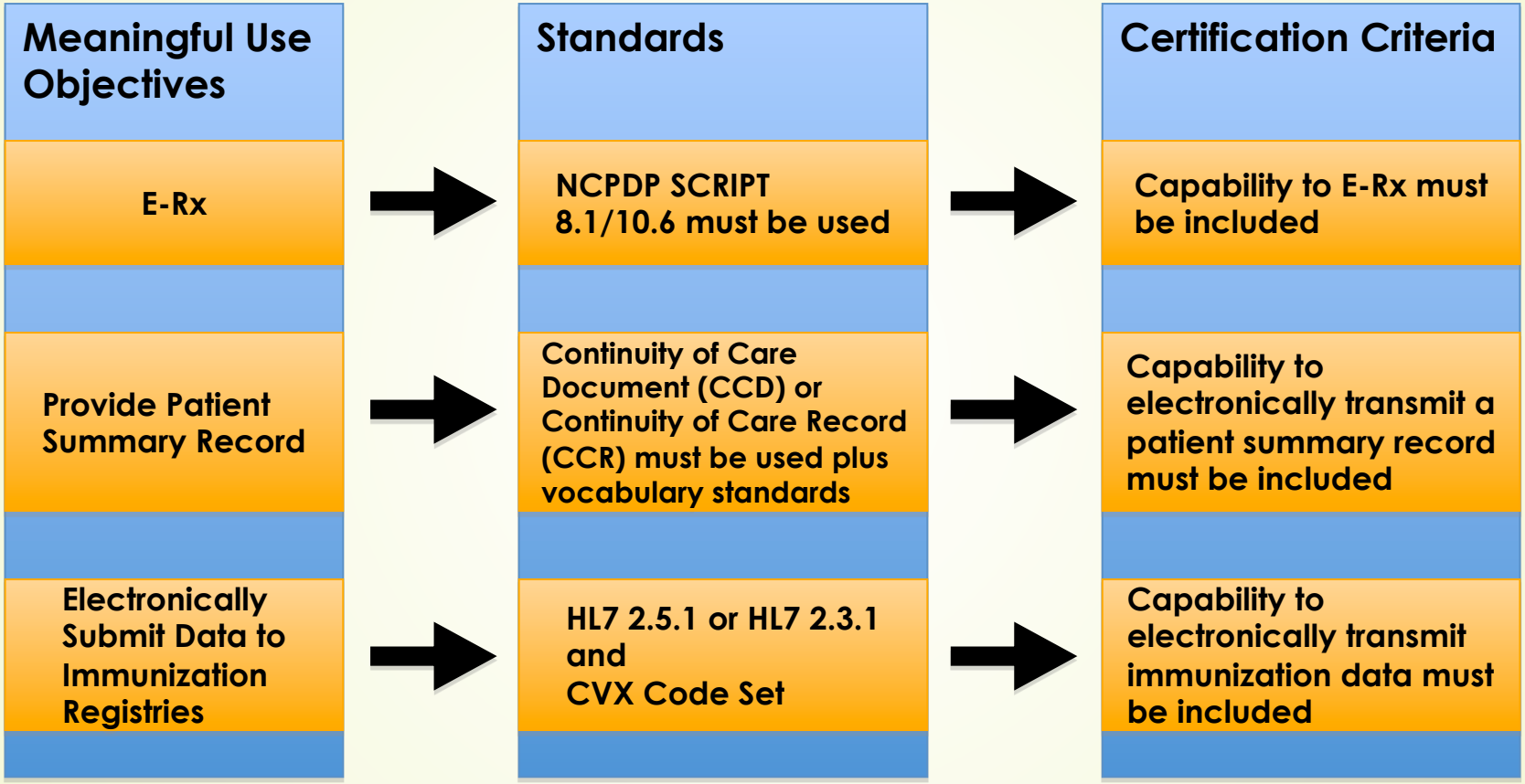
Aligning Certification and Standards



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

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The Final Rule

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

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Incentive Program Key Provisions

Eligibility

- Eligible professionals (EPs) must choose between Medicare & Medicaid Incentives, but may switch once
- Eligible Hospitals and Critical Access Hospitals (EHs) can receive both Medicare and Medicaid incentives

Timeframe for Demonstrating Meaningful Use (MU):

- In the 1st year of demonstrating meaningful use, each hospital or professional must demonstrate MU over any continuous 90 period within a calendar (EP) or federal fiscal (EH) year.
  - Note: This could be the second payment year if money was received from Medicaid for adopt, implement, upgrade
- For subsequent years, individual providers must demonstrate MU over the entire reporting year.

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

- Eligible hospitals and professionals can receive incentives for adoption, implementation and upgrade of certified EHR technology in their first year of participation
- "Adopt, implement, or upgrade" means:
  - Install or commence utilization of certified EHR technology capable of meeting meaningful use requirements; or
  - Expand the functionality of certified EHR technology capable of meeting meaningful use requirements at the practice site, including staffing, maintenance, and training.
  - Upgrade from existing EHR technology to certified EHR technology per the ONC EHR certification criteria.
- For a hospital, this would *not* count as your first payment year for Medicare

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Incentive Payments to Eligible Professionals

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

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Definition of a Medicare Eligible Professional

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

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

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

1. Professionals with >50% Medicare services (as opposed to charges) in a health professional shortage area see a 10% increase in the maximum payment
2. Must demonstrate and attest to MU by October 1 2014 to avoid the 2015 penalty

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Professional EHR Reporting Period

- Professionals who have demonstrated meaningful use in 2011 through 2013 (fiscal years)

Payment Adjustment Year	2015	2016	2017	2018	2019	2020
EHR Reporting Period	2013	2014	2015	2016	2017	2018

- Professional who demonstrates meaningful use in 2014 for the first time

Payment Adjustment Year	2015	2016	2017	2018	2019	2020
90 day EHR Reporting Period	2014*	2014				
Full Year EHR Reporting Period			2015	2016	2017	2018

* In order to avoid the 2015 payment adjustment the professional must attest no later than October1, 2014

EP EHR Reporting Period

- EP who demonstrates meaningful use in 2014 for the first time:

Payment Adjustment Year	2015	2016	2017	2018	2019	2020
90 day EHR Reporting Period	2014*	2014				
Full Year EHR Reporting Period			2015	2016	2017	2018

* In order to avoid the 2015 payment adjustment the EP must attest no later than Oct 1, 2014 which means they must begin their 90 day EHR reporting period no later than July 2, 2014

Medicaid Eligible Professional

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

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Medicaid Eligible Professional, cont.

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

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

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EP Medicaid Volume Calculation

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

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Calculating Eligible Professional Medicaid Incentives

- For professionals with >30% threshold, the incentive amount is:
  - $21,250 for the first payment year
  - $8500 for each of the following 5 years
- For pediatric physicians with between 20% and 30% Medicaid, the incentive amount is one third lower:
  - $14,167 in the first payment year
  - $5,667 for each of the following 5 years
- The first payment year can be as late as 2016

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Maximum Medicaid Incentives for EPs with ≥ 30% volume

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

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Notable Differences Between the Medicare & Medicaid Incentives

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

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Deciding Between Medicare and Medicaid

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

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Definition of an Medicare Eligible Hospital

- A subsection (d) hospital defined in the Social Security Act, essentially an acute care facility:
  - Located in the 50 states
  - Not a psychiatric, rehabilitative, predominately pediatric or cancer facility.
  - Where average length of stay is 25 days or less
- A critical access hospital
- Individual or groups of hospitals that have the same CMS Certification Number (CCN) for cost reporting (OSCAR number) are seen as one hospital

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PPS* EH Medicare Incentives

($2M + Discharge Amount) × Medicare Share × Transition %:

Discharge amount:

$$\$200 \times (\#\ of\ discharges \geq 1{,}150\ and \leq 23{,}000)$$

The Medicare share (MS):

$$\frac{Medicare\ Inpatient\ Days}{Total\ Inpatient\ Days \left(\frac{Gross\ Revenue - Charity}{Gross\ Revenue} \right)}$$

Transition Percentage:

Based on the payment year and the fiscal year

* PPS = Prospective Payment System

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Medicare Incentives for Eligible PPS Hospitals[1]

2010	2011	2012	2013	2014	2015	2016	2017	% Max Payment
	Stage 1 100%	Stage 1 75%	Stage 1 50%	Stage 2 25%	Stage 2	Stage 3	Stage 3	100%
		Stage 1 100%	Stage 1 75%	Stage 2 50%	Stage 2 25%	Stage 3	Stage 3	100%
			Stage 1 100%	Stage 1 75%	Stage 2 50%	Stage 2 25%	Stage 3	100%
				Stage 1[2] 75%	Stage 1 50%	Stage 2 25%	Stage 2	60%
					Stage 1 50%	Stage 1 25%	Stage 2	30%
						Stage 1	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, 2014 to avoid the 2015 penalty

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Subsection (d) Hospital EHR Reporting Period

- Hospital who has demonstrated meaningful use in 2011 through 2013 (fiscal years)

Payment Adjustment Year	2015	2016	2017	2018	2019	2020
Meaningful User Year	2013	2014	2015	2016	2017	2018

- Hospital who demonstrates meaningful use in 2014 for the first time

Payment Adjustment Year	2015	2016	2017	2018	2019	2020
90 day EHR Reporting Period	2014*	2014				
Full Year EHR Reporting Period			2015	2016	2017	2018

* In order to avoid the 2015 payment adjustment the hospital must attest no later than July 1, 2014

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Eligible CAH Medicare Incentives

Reasonable EHR costs × Medicare Share plus

Reasonable EHR costs:

- *Software / hardware costs during the first payment year plus the undepreciated costs less interest from previous periods*
- *Software / hardware costs for other payment years*
- *Determined by your Medicare intermediary (Noridian in MN & ND)*

Medicare Share Plus

Medicare Share (MS%):

$$\frac{Medicare\ Inpatient\ Days}{Total\ Inpatient\ Days\left(\frac{Gross\ Revenue - Charity}{Gross\ Revenue}\right)}$$

Plus:

MS% + 20% or 100% whichever is less

Paid on an interim basis for up to 4 years or through 2015

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Medicare Incentives for Eligible Critical Access Hospitals

2010	2011	2012	2013	2014	2015	2016	2017	Payments
	Stage 1 Payment	Stage 1 Payment	Stage 1 Payment	Stage 2 Payment	Stage 2	Stage 3	Stage 3	4
		Stage 1 Payment	Stage 1 Payment	Stage 2 Payment	Stage 2 Payment	Stage 3	Stage 3	4
			Stage 1 Payment	Stage 1 Payment	Stage 2 Payment	Stage 2	Stage 3	3
				Stage 1 Payment	Stage 1 Payment	Stage 2	Stage 2	2
					Stage 1 Payment	Stage 1	Stage 2	1
						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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CAH EHR Reporting Period

- CAH who has demonstrated meaningful use prior to the 2015 fiscal year

Payment Adjustment Year	2015	2016	2017	2018	2019	2020
Full Year EHR Reporting Period	2015	2016	2017	2018	2019	2020

- CAH who demonstrates meaningful use in 2015 for the first time

Payment Adjustment Year	2015	2016	2017	2018	2019	2020
90 day EHR Reporting Period	2015					
Full Year EHR Reporting Period		2016	2017	2018	2019	2020

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Medicaid Eligible Hospital Definition

- Acute Care Hospital or Critical Access Hospital
  - Same definition as Medicare
- Added:
  - Cancer Hospitals
  - Freestanding Children's Hospitals
- It continues to exclude psychiatric, rehabilitation, and long-term care hospitals.
- Non pediatric hospitals must have a Medicaid patient volume >10%

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Eligible Hospital Medicaid Incentives

- Maximum aggregate payment is the calculated Medicaid share cost of EHR defined as sum of annually adjusted payment years 1 to 4 of:

  $(\$2M + (Discharge\ Amount \times Annual\ Adjustment) \times Medicaid\ Share \times Transition\ \%)$

  Discharge amount:

  $\$200 \times (\#\ of\ discharges \geq 1{,}150\ and \leq 23{,}000)$

  Annual Adjustment:

  $Average\ annual\ rate\ of\ growth\ for\ the\ most\ recent\ 3\ years$

  The Medicaid share (MS):

  $$\frac{Total\ Medicaid\ +\ Medicaid\ Managed\ Care\ Inpatient\ Days}{Total\ Inpatient\ Days\left(\frac{Gross\ Revenue - Charity}{Gross\ Revenue}\right)}$$

  Transition Percentage:

  $100\%\ Yr1,\ 75\%\ Yr2,\ 50\%\ Yr3,\ 25\%\ Yr4$

- Total paid over a 3 to 6 years starting as late as 2016

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Maximum Medicaid Incentives for Eligible Hospitals

		First Year of Adopt, implement, Upgrade or MU Demonstration						
		2011	2012	2013	2014	2015	2016	2011
Calendar Year	2011	Y1						Y1
	2012	Y2	Y1					
	2013	Y3	Y2	Y1				Y2
	2014	Y4	Y3	Y2	Y1			
	2015	Y5	Y4	Y3	Y2	Y1		
	2016	Y6	Y5	Y4	Y3	Y2	Y1	Y3
	2017		Y6	Y5	Y4	Y3	Y2	Y4
	2018			Y6	Y5	Y4	Y3	Y5
	2019				Y6	Y5	Y4	Y6
	2020					Y6	Y5	
	2021						Y6	
	Total:	Calculated Medicaid share or EHR Cost						

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Notable Differences Between the Medicare & Medicaid Incentives

	Medicare	Medicaid
Availability	Nationally	States choose to implement
Consistent across nation	MU definition will be common for Medicare	States can adopt a more rigorous definition for hospitals participating only in Medicaid
Reimbursement for eligible hospitals	Based on Medicare share of days (PPS) or on EHR cost (CAH)	Based on Medicaid share of days
Types of eligible hospitals	Acute adult PPS and CAH	Acute adult, CAH, pediatric and oncology
First payment year	Demonstrate meaningful use over a continuous 90 days in a federal fiscal year	Can be for adopt, implement or upgrade only
Subsequent payment years	Must be consecutive	Needn't be consecutive for hospitals until after 2016
Payments	No payments for years after 2016 for PPS Hospitals and 2015 for CAH	Payments can start as late as 2016 and no payments after 2021
Last year to initiate program	PPS Hospital 2015, CAH, 2014	2016
Penalties if not a MUser	Yes, starting in 2015	No

Incentive Program Statistics as of March 1

- $3.9 billion paid to hospitals and professionals
- 1252 ambulatory and 642 inpatient products have become certified
- Eligible Professionals
  - 208,000 have registered
  - 60,000 have received incentives
- Eligible Hospitals
  - 3,355 have registered
  - 2,355 have received incentives

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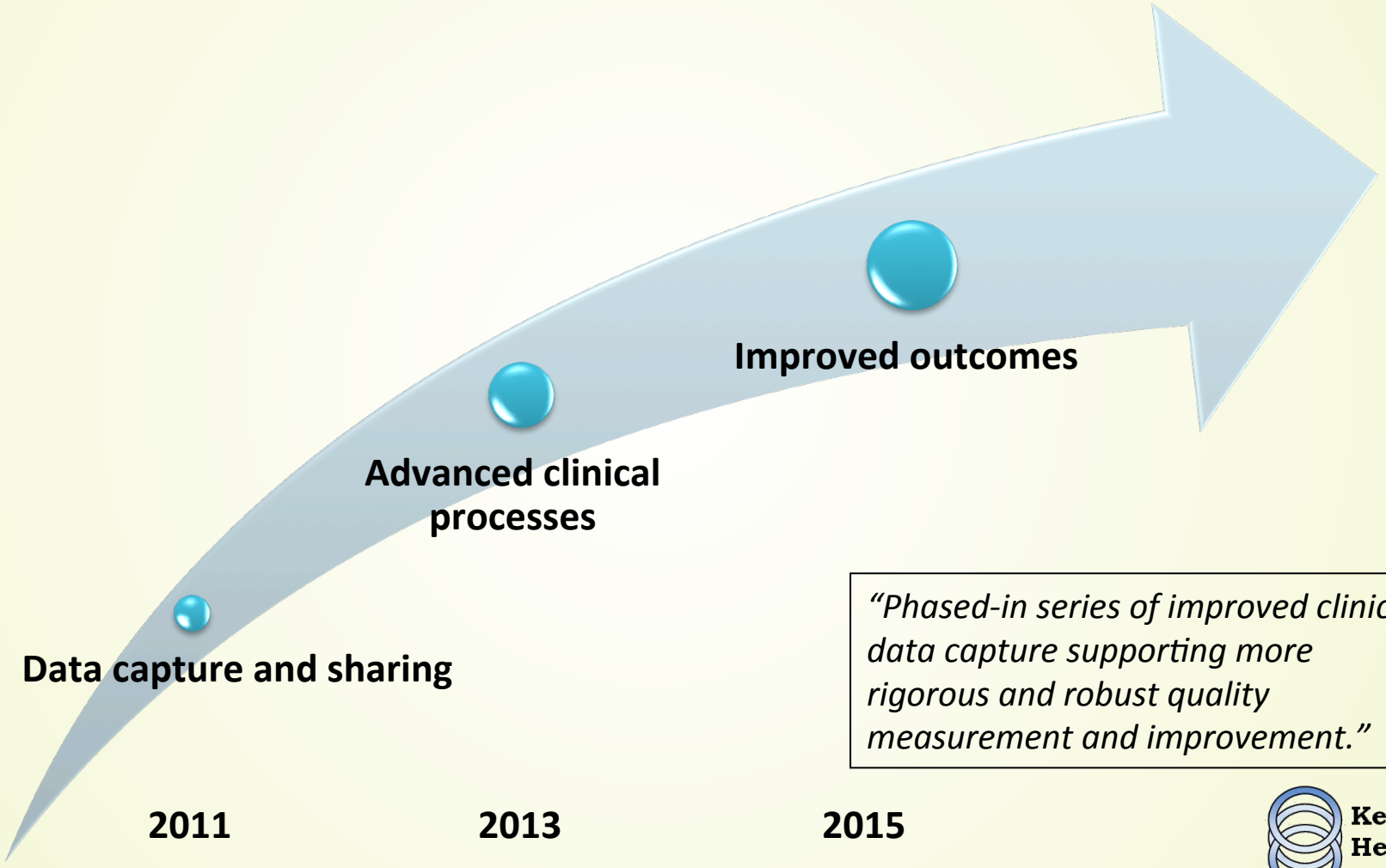
Meaningful Use Criteria

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

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

Bending the Curve Towards Transformed Health



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

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

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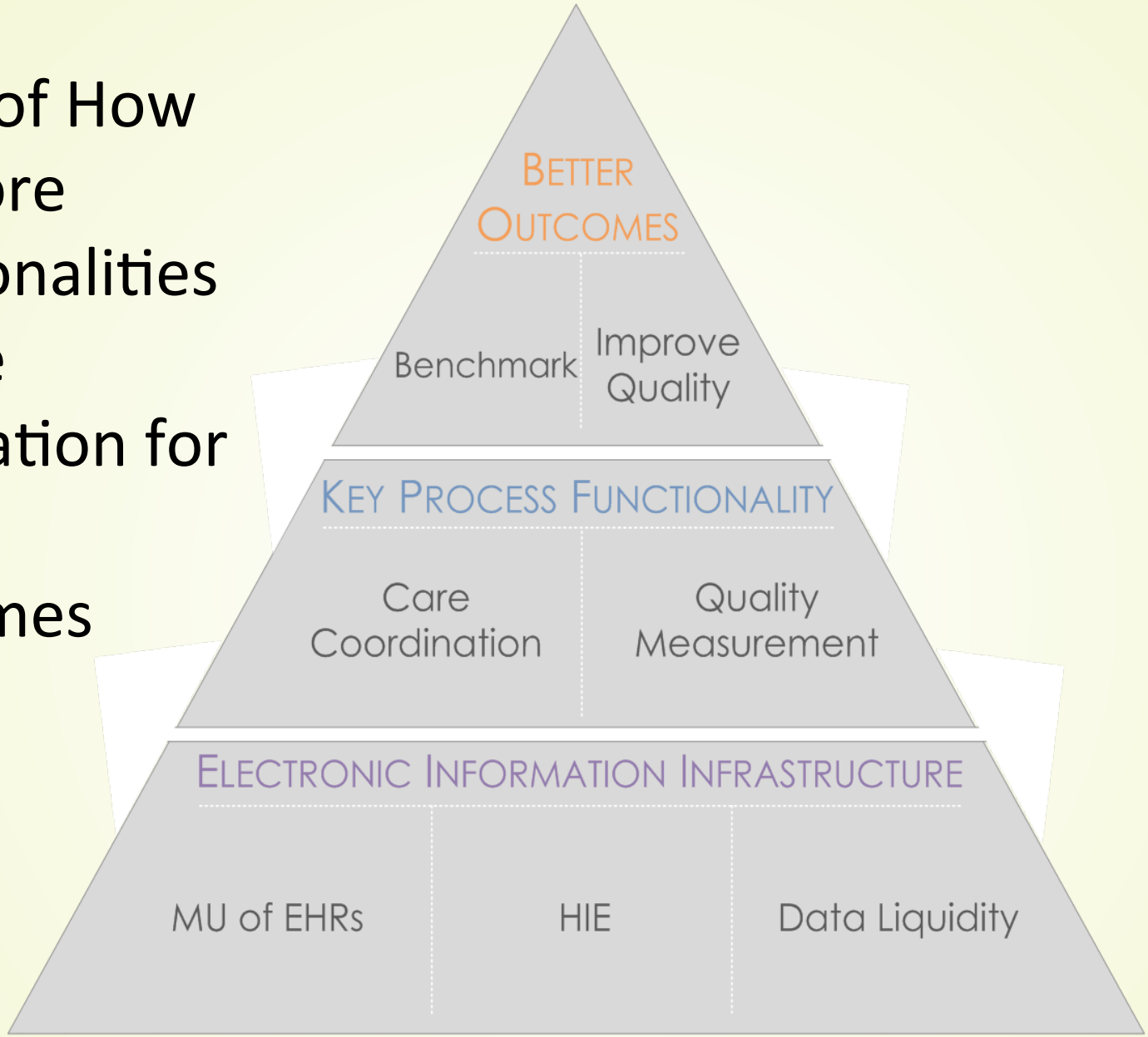
Vision of How EHR Core Functionalities Lay the Foundation for Better Outcomes



Adapted from the HIT Policy Committee Presentation June 8, 2011

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"Stage 1" Meaningful Use Criteria

- 25 objectives and measures for eligible professionals (EP)
  - 15 are required ("core"), up to 5 of the remaining 10 may be deferred to Stage 2 ("menu")
  - 9 require yes/no, 16 require submitting a numerator and denominator (n/d)
- 24 objectives and measures for eligible hospitals (EH)
  - 14 are required ("core"), up to 5 of the remaining 10 may be deferred to Stage 2 ("menu")
  - 10 require yes/no, 14 require n/d submission

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Methods of Counting: ED Visits vs. Observation Services

- Eligible hospitals and CAHs must select one of the following methods to be applied consistently to all denominators for the measures.
- *Observation Services method. The denominator should include the following visits to the ED:*
  - The patient is admitted to the inpatient setting (place of service (POS) 21) through the ED. Actions in the ED using certified EHR technology would count toward Meaningful Use measures.
  - The patient initially presented to the ED and is treated in the ED's observation unit or other observation services.
- *All ED Visits method.*
  - Include all ED visits in the denominator for all measures. All actions taken in the inpatient or emergency departments of the hospital would count for purposes of determining meaningful use.

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Core and Menu Criteria

- Hospitals and professionals must complete each of the core criteria unless unable to due to scope of practice, population served or number in the denominator. For example:
  - Chiropractor and e-prescribing
  - No patients request electronic copies of their discharge instructions or their health information

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Core Criteria (page 1 of 3)

	Objective	Measure
Improve quality, safety, efficiency and reduce health disparities	CPOE[1] (Lic HC Prof)	>30% of patients on any meds with ≥ one CPOE med order (Proposed for 2013: may use >30% all orders) (n/d)
	Drug (D-A, D-D) Interactions	Turned on (y/n)
	ePrescribe[1] (EP)	>40% of permissible scripts (n/d)
	Demographics	>50% of patients seen: language, gender, race, ethnicity, and DOB. For EHs: date and preliminary cause of death (n/d)
	Problem List	>80% of patients seen at least one or "none" *as structured data* (n/d)
	Med List	
	Med Allergies	

1. CPOE and ePrescribe excluded if < 100 scripts written

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Core Criteria (page 2 of 3)

	Objective	Measure
Improve quality, safety, efficiency and reduce health disparities	Vitals[1]	>50% of patients ≥ 2yo seen: height, weight, BP, BMI, & for age 2-20: growth charts w/BMI (Proposed for 2013: may split BP and height-weight, also may use only ≥ 3 for BP) (n/d)
	Smoking	>50% of patients ≥ 13yo seen, record status *as structured data* (n/d)
	Decision Support	1 CDS rule relevant to the specialty specific quality metric (EP) or high priority hospital condition (EH) *with the ability to track compliance* (y/n)
	Quality Reporting	Report quality measures to CMS or states 2011: Attest numerator/denominator 2012: Electronic submission optional

1. Exclusion if pts ht, wt, & BP have no relevance to scope of practice

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Core Criteria (page 3 of 3)

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

1. Clinical information must be sent between different legal entities with distinct certified EHR technology or other system that can accept the information and not between organizations that share certified EHR technology
2. "Diagnostic test results " are all data needed to diagnose and treat disease, such as blood tests, microbiology, urinalysis, pathology tests, radiology, cardiac imaging, nuclear medicine tests, and pulmonary function tests.

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Menu Criteria

- Professionals and hospitals may defer up to 5 of the menu criteria until stage 2
- At least one of the criteria from population and public health must be included in order to qualify as a meaningful user
- If a professional or hospital is unable to complete one of the menu items due to scope of practice, they may still defer 5 menu items through 2013 only

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Menu Criteria (page 1 of 2)

	Objective	Measure
Improve quality, safety, efficiency and reduce health disparities	Formularies	Implement drug formulary checks with at least one internal or external formulary (y/n)
	Advanced Directives (EH)	>50% of ≥ 65yo admitted indicate advanced directive recorded (n/d EHR non ED)
	Lab Results	>40% of labs with numeric or +/- result in chart as structured data (n/d)
	Patient Lists[1]	Generate at least one pt list based on a specific condition (y/n)
	Reminders (EP)	>20% of pts ≥ 65 or ≤ 5yo sent reminders for follow up care (n/d)
Engage Patients and Families in Their Health Care	eAccess (EP)	>10% patients seen with electronic access to lab results, prob lists, med list, med allergies w/i 4 business days of it being updated in the EHR (n/d)
	Patient Ed	>10% patients seen provided with educational resources identified with the EHR (n/d)

1. States may seek approval from CMS to require a specific condition be tracked for Medicaid

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Menu Criteria (page 2 of 2)

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

1. Unless an EP, eligible hospital or CAH has an exception for all of these objectives and measures they must complete at least one in this group as part of their demonstration of a meaningful EHR use to be eligible for incentives.
2. States may specify how to test the data submission and to which specific destination

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Meaningful Use Specification Sheet

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

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Professional Criteria Specification Sheet

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

Eligible Professional Core Objectives		
(1)	Use CPOE for medication orders directly entered by any licensed healthcare professional who can enter orders into the medical record per state, local and professional guidelines.	AVAILABLE
(2)	Implement drug-drug and drug-allergy interaction checks.	AVAILABLE
(3)	Maintain an up-to-date problem list of current and active diagnoses.	AVAILABLE
(4)	Generate and transmit permissible prescriptions electronically (eRx).	AVAILABLE
(5)	Maintain active medication list.	AVAILABLE
(6)	Maintain active medication allergy list.	AVAILABLE
(7)	Record all of the following demographics: (A) Preferred language. (B) Gender. (C) Race. (D) Ethnicity. (E) Date of birth.	AVAILABLE
(8)	Record and chart changes in the following vital signs: (A) Height. (B) Weight.	

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Hospital Criteria Specification Sheet

EHR Incentive Program

Eligible Hospital and CAH Meaningful Use Table of Contents Core and Menu Set Objectives

Eligible Hospital and CAH Core Objectives		
(1)	Use CPOE for medication orders directly entered by any licensed healthcare professional who can enter orders into the medical record per State, local, and professional guidelines.	AVAILABLE
(2)	Implement drug-drug and drug-allergy interaction checks.	AVAILABLE
(3)	Maintain an up-to-date problem list of current and active diagnoses.	AVAILABLE
(4)	Maintain active medication list.	AVAILABLE
(5)	Maintain active medication allergy list.	AVAILABLE
(6)	Record all of the following demographics: (A) Preferred language. (B) Gender. (C) Race. (D) Ethnicity. (E) Date of birth. (F) Date and preliminary cause of death in the event of mortality in the eligible hospital or CAH.	AVAILABLE
(7)	Record and chart changes in the following vital signs: (A) Height. (B) Weight. (C) Blood pressure. (D) Calculate and display body mass index (BMI).	AVAILABLE

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Criteria:

Core:

All Patients:

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

EHR Patients:

- CPOE
- E-Prescribing (EP only)
- Vital signs
- Smoking status
- E-copy of their health information
- E-copy of discharge instructions (EH only)
- Clinical summaries (EP Only)

On (Yes or No):

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

Menu:

All Patients:

- E-access to their health information. (EP only)
- Provide patient-specific education resources

EHR Patients:

- Advanced directives (EH only)
- Labs as structured data
- Patient reminders (EP only)
- medication reconciliation
- Summary of care record

On (Yes or No):

- Drug - formulary checks
- Patient list by specific condition
- Test of submission of electronic data to immunization registries. *
- Test of 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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Small Groups

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Outline

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  - For Professionals
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- Closure

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Quality Measures

- Relate to healthcare quality aims such as effective, safe, efficient, patient-centered, equitable, and timely care.
- Drawn primarily from PQRI and NQF endorsed measures
- EPs would be required to submit clinical data on 6 measures from 2 measure groups:
  - A core set of 3 measures (or alternates)
  - 3 additional measures selected from among 38 others
- Hospitals are required to report on all 15 hospital measures
- All have specifications for electronic reporting
- Reporting limited to patients in the EHR
- Patient information must be submitted regardless of payer

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Reporting of Clinical Quality Measures

- For the 2012 payment year :
  - Professionals have a choice
    - To CMS by attestation as in 2011 or
    - Through PQRS as a pilot
    - To the states if choosing Medicaid
  - Hospitals also have a choice:
    - To CMS by attestation as in 2011 or
    - Through the hospital IQR program
      - Formerly known as the Reporting Hospital Quality Data for Annual Payment Update (RHQDAPU) program
    - To the states if choosing only Medicaid

For more info, see: http://www.cms.gov/EHRIncentivePrograms/31_ClinicalQualityMeasures.asp

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Reporting of Clinical Quality Measures

- EPs would be required to submit clinical data on 2 measure groups:
  - A core set of 3 measures (or alternates)
  - 3 additional measures selected from among 38 others

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Core Quality Measures for EPs

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

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Core: NQF 0013: Hypertension: BP Measurement

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

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Core: NQF 0028a: Tobacco Use Assessment

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

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Core: NQF 0028b: Tobacco Use Assessment

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

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

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

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

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

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

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

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

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

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Alt Core: NQF 0038: Childhood Immunization Status

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

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Optional Quality Measures – Diabetes

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

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Optional Quality Measures – Cardiovascular Disease

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

Optional Quality Measures – Prevention

- 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

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Optional Quality Measures – Other

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

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Additional Quality Measures – Other

- 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

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Reporting of Clinical Quality Measures

- Eligible hospitals will be be required to submit data on all 15 measures

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Hospital Measures

Measure Number	Clinical Quality Measure Title & Description
ED-1 NQF 0495	ED Throughput – admitted patients: Median time from ED arrival to ED departure for admitted patients
ED-2 NQF 0497	ED Throughput – admitted patients: Admission decision time to ED departure time for admitted patients
Stroke-2 NQF 0435	Ischemic stroke – Discharge on anti-thrombotics
Stroke-3 NQF 0436	Ischemic stroke – Anticoagulation for A-fib/flutter
Stroke-4 NQF 0437	Ischemic stroke – Thrombolytic therapy for patients arriving within 2 hours of symptom onset
Stroke-5 NQF 0438	Ischemic or hemorrhagic stroke – Antithrombotic therapy by day 2
Stroke-6 NQF 0439	Ischemic stroke – Discharge on statins

Measure Number	Clinical Quality Measure Title & Description
Stroke-8 NQF 0440	Ischemic or hemorrhagic stroke – Stroke education
Stroke-10 NQF 0441	Ischemic or hemorrhagic stroke – Rehabilitation assessment
VTE-1 NQF 0371	VTE prophylaxis within 24 hours of arrival
VTE-2 NQF 0372	Intensive Care Unit VTE prophylaxis
VTE-3 NQF 0373	Anticoagulation overlap therapy
VTE-4 NQF 0374	Platelet monitoring on unfractionated heparin
VTE-5 NQF 0375	VTE discharge instructions
VTE-6 NQF 0376	Incidence of potentially preventable VTE

ED-1, NQF 0495: ED Throughput - Arrival to Departure

- Description:
  - Median time from emergency department arrival to time of departure for patients admitted.
- Denominator
  - All Emergency Department (ED) patients admitted to the facility from the ED.
- Numerator
  - Median time (in minutes) from ED arrival to ED departure for all patients in the denominator.
- Stratification
  - Non observation or mental health patients
  - ED observation patients
  - Mental health patients

HITSP V1.1 2010 TN906 - Quality Measures Technical Note ED Stroke VTE, p 140-43

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ED-2, NQF 0497: ED Throughput - Admission Decision to Departure

- Description:
  - Median time from admit decision time to time of departure of emergency department patients admitted to inpatient status.
- Denominator
  - All Emergency Department (ED) patients admitted to the facility from the ED to inpatient status.
- Numerator
  - Median time (in minutes) from admit decision time to time of departure from the ED for all patients in the denominator.
- Stratification
  - Non-observation & mental health patients
  - ED observation patients
  - Mental health patients as principal diagnosis

HITSP V1.1 2010 TN906 - Quality Measures Technical Note ED Stroke VTE, p144-46

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Stroke-2, NQF 0435: Ischemic stroke - D/C on anti-thrombotics

- Description:
  - Ischemic stroke patients prescribed antithrombotic therapy at hospital discharge
- Denominator
  - Patients admitted to and discharged from the hospital for inpatient acute care with a Principal Diagnosis Code for ischemic stroke as defined by value set "Joint Commission Ischemic Stroke Value Set"
- Numerator
  - All patients in the denominator prescribed anti-thrombotic therapy at hospital discharge
- Exclusions
  - Age < 18
  - Length of stay >120 days
  - Comfort measures only documented
  - Enrolled in clinical trial
  - Admitted for elective carotid intervention
  - Discharged/transferred to another hospital for inpatient care
  - Left against medical advice or discontinued care
  - Expired
  - Discharged/transferred to a federal healthcare facility
  - Discharged/transferred to hospice
  - A documented reason for not prescribing anti-thrombotic therapy at discharge

HITSP V1.1 2010 TN906 - Quality Measures Technical Note ED Stroke VTE, p 48-52

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Stroke-3, NQF 0436: Ischemic Stroke - Anticoagulation for A-fib/flutter

- Description:
  - Ischemic stroke patients with atrial fibrillation/flutter who are prescribed anticoagulation therapy at hospital discharge.
- Denominator
  - Patients admitted to and discharged from the hospital for inpatient acute care with a Principal Diagnosis Code for ischemic stroke as defined by value set "Joint Commission Ischemic Stroke Value Set" and with with documented Atrial Fibrillation/Flutter
- Numerator
  - All patients in the denominator prescribed anti-thrombotic therapy at hospital discharge
- Exclusions
  - Age < 18
  - Length of stay >120 days
  - Comfort measures only documented
  - Enrolled in clinical trial
  - Admitted for elective carotid intervention
  - Discharged/transferred to another hospital for inpatient care
  - Left against medical advice or discontinued care
  - Expired
  - Discharged/transferred to a federal healthcare facility
  - Discharged/transferred to hospice
  - A documented reason for not prescribing anti-thrombotic therapy at discharge

HITSP V1.1 2010 TN906 - Quality Measures Technical Note ED Stroke VTE, p 53-57

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Stroke-4, NQF 0437: Ischemic Stroke - Thrombolytic therapy

- Description:
  - Acute ischemic stroke patients who arrive at this hospital within 2 hours of time last known well and for whom **IV t-PA was initiated at this hospital within 3 hours of time last known well**.
- Denominator
  - Acute ischemic stroke patients whose time of arrival is within 2 hours of time last known well, admitted to and discharged from the hospital for inpatient acute care with a Principal Diagnosis Code for ischemic stroke as defined by value set "Joint Commission Ischemic Stroke Value Set"
- Numerator
  - All patients in the denominator for whom IV thrombolytic therapy was initiated at this hospital within 3 hours of time last known well.
- Exclusions
  - Age < 18
  - Length of stay >120 days
  - Enrolled in clinical trial
  - Admitted for elective carotid intervention
  - Time last known well to arrival in the emergency department > 2 hours
  - A documented reason for not initiating IV thrombolytic therapy

HITSP V1.1 2010 TN906 - Quality Measures Technical Note ED Stroke VTE, p 58-64

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Stroke-5, NQF 0438: Ischemic Stroke – Anti-thrombotic Therapy

- Description:
  - Ischemic stroke patients administered antithrombotic therapy by the end of hospital day 2.
- Denominator
  - Acute ischemic stroke patients discharged from the hospital with a Principal Diagnosis Code for ischemic stroke as defined by value set "Joint Commission Ischemic Stroke Value Set"
- Numerator
  - All patients in the denominator who had antithrombotic therapy administered by end of hospital day 2.
- Exclusions
  - Age < 18
  - Length of Stay >120 Days
  - Patients discharged by end of hospital day 2
  - Comfort measures only documented on day of or day after arrival
  - Enrolled in Clinical Trial
  - Admitted for Elective carotid intervention
  - Patients with thrombolytic therapy administered at this hospital or within 24 hours prior to arrival
  - A documented reason for not administering antithrombotic therapy

HITSP V1.1 2010 TN906 - Quality Measures Technical Note ED Stroke VTE, p 65-70

Stroke-6, NQF 0439: Ischemic Stroke – Discharge on Statins

- Description:
  - Ischemic stroke patients with LDL ≥ 100 mg/dL, or LDL not measured, or, who were on a lipid-lowering medication prior to hospital arrival are prescribed statin medication at hospital discharge.
- Denominator
  - Ischemic stroke patients with an LDL >= 100 mg/dL, OR LDL not measured, OR who were on a lipid-lowering medication prior to hospital arrival discharged from the hospital with a Principal Diagnosis Code for ischemic stroke as defined by value set "Joint Commission Ischemic Stroke Value Set"
- Numerator
  - All patients in the denominator prescribed statin medication at hospital discharge.
- Exclusions
  - Patients with (age <18)
  - Length of stay >120 days
  - Comfort measures only documented
  - Enrolled in clinical trial
  - Admitted for elective carotid intervention
  - No evidence of atherosclerosis
  - Discharged/transferred to another hospital for inpatient care
  - Left against medical advice or discontinued care
  - Expired
  - Discharged/transferred to a federal healthcare facility
  - Discharged/transferred to hospice
  - A reason for not prescribing statin medication at discharge

HITSP V1.1 2010 TN906 - Quality Measures Technical Note ED Stroke VTE, p 71-78

Stroke-8, NQF 0440: All Stroke – Stroke Education

- Description:
  - Ischemic or hemorrhagic stroke patients or their caregivers who were given educational materials during the hospital stay.
- Denominator
  - Ischemic stroke or hemorrhagic stroke patients discharged home with a Principal Diagnosis Code for ischemic or hemorrhagic stroke as defined by value set "Joint Commission Ischemic Stroke Value Set"
- Numerator
  - All patients in the denominator with documentation that they or their caregivers were given educational material addressing all of the following:
    - Activation of emergency medical system
    - Need for follow-up after discharge
    - Medications prescribed at discharge
    - Risk factors for stroke
    - Warning signs for stroke
- Exclusions
  - Age < 18
  - Length of stay >120 days
  - Comfort measures only documented
  - Enrolled in clinical trial
  - Admitted for elective carotid intervention

HITSP V1.1 2010 TN906 - Quality Measures Technical Note ED Stroke VTE, p 79-84

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Stroke-10, NQF 0441: All Stroke – Rehabilitation Assessment

- Description:
  - Ischemic or hemorrhagic stroke patients who were assessed for rehabilitation services.
- Denominator
  - Discharges with a Principal Diagnosis Code for ischemic or hemorrhagic stroke as defined by value set "Joint Commission Ischemic Stroke Value Set"
- Numerator
  - All patients in the denominator assessed for or who received rehabilitation services
- Exclusions
  - Patients with (age <18)
  - Length of stay >120 days
  - Comfort measures only documented
  - Enrolled in clinical trial
  - Admitted for elective carotid intervention
  - Discharged/transferred to another hospital for inpatient care
  - Left against medical advice or discontinued care
  - Expired
  - Discharged/transferred to a federal healthcare facility
  - Discharged/transferred to hospice

HITSP V1.1 2010 TN906 - Quality Measures Technical Note ED Stroke VTE, p 85-90

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VTE-1, NQF 0371: Venous Thromboembolism VTE Prophylaxis Within 24 Hours Of Arrival

- Description:
  - The number of patients who received VTE prophylaxis or have documentation why no VTE prophylaxis was given the day of or the day after hospital admission or surgery end date for surgeries that start the day of or the day after hospital admission.
- Denominator
  - All patients.
- Numerator
  - All patients in the denominator who received VTE prophylaxis or have documentation why no VTE prophylaxis was given
    - the day of or the day after hospital admission
    - the day of or the day after surgery end date for surgeries that start the day of or the day after hospital
- Exclusions
  - Age < 18
  - Patients who have a length of stay < 2 days
  - Length of stay >120 days
  - Comfort measures only documented on day of or day after hospital arrival
  - Enrolled in clinical trial
  - Direct admits to intensive care unit (ICU), or transferred to ICU the day of or the day after hospital admission with ICU LOS ≥ one day
  - A principal diagnosis of mental disorders
  - A principal diagnosis of hemorrhagic or ischemic stroke
  - A principal diagnosis of obstetrics
  - A principal diagnosis of VTE

HITSP V1.1 2010 TN906 - Quality Measures Technical Note ED Stroke VTE, p 91-103

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VTE-2, NQF 0372: Venous Thromboembolism Intensive Care Unit VTE prophylaxis

- Description:
  - The number of patients who received VTE prophylaxis or have documentation why no VTE prophylaxis was given the day of or the day after the initial admission (or transfer) to the Intensive Care Unit (ICU) or surgery end date for surgeries that start the day of or the day after ICU admission (or transfer).
- Denominator
  - Patients who are direct admits to intensive care unit (ICU), or transferred to ICU the day of or the day after hospital admission with ICU LOS ≥ one day .
- Numerator
  - All patients in the denominator who received VTE prophylaxis or have documentation why no VTE prophylaxis was given
    - The day of or the day after ICU admission (or transfer)
    - The day of or the day after surgery end date for surgeries that start the day of or the day after ICU admission (or transfer
- Exclusions
  - Age < 18
  - Patients who have a length of stay < 2 days
  - Length of stay >120 days
  - Comfort measures only documented on day of or day after hospital arrival
  - Enrolled in clinical trial
  - ICU LOS < one day without VTE prophylaxis administered and without documentation for no VTE prophylaxis
  - Patients with principal diagnosis of obstetrics
  - Patients with principal diagnosis of VTE

HITSP V1.1 2010 TN906 - Quality Measures Technical Note ED Stroke VTE, p 104-15

VTE-3, NQF 0373: Venous Thromboembolism Anticoagulation Overlap Therapy

- Description:
  - The number of patients diagnosed with confirmed VTE who received an overlap of parenteral anticoagulation and warfarin therapy. For patients who received less than five days of overlap therapy, they must be discharged on both medications. Overlap therapy must be administered for at least five days with an international normalized ratio (INR) ≥ 2 prior to discontinuation of the parenteral anticoagulation therapy or the patient must be discharged on both medications.
- Denominator
  - Patients with confirmed VTE who received warfarin with a Principal Diagnosis Code or Other Diagnosis Code for VTE Confirmed as defined by Value set for —Joint Commission VTE Confirmed Value Set
- Numerator
  - All patients in the denominator who received overlap therapy who received warfarin and parenteral (intravenous or subcutaneous) anticoagulation:
    - Five or more days, with an INR ≥ 2 prior to discontinuation of parenteral therapy OR
    - Five or more days, with an INR < 2 and discharged on overlap.
- Exclusions
  - Age < 18
  - Length of stay >120 days
  - Comfort measures only
  - Enrolled in clinical trial
  - Without warfarin therapy during hospitalization
  - Without warfarin prescribed at discharge
  - Without VTE confirmed by diagnostic testing

HITSP V1.1 2010 TN906 - Quality Measures Technical Note ED Stroke VTE, p 116-22

VTE-4, NQF 0374: Venous Thromboembolism Platelet Monitoring On Unfract. Heparin

- Description:
  - The number of patients diagnosed with confirmed VTE who received intravenous (IV) unfractionated heparin (UFH) therapy dosages AND had their platelet counts monitored using defined parameters such as a nomogram or protocol.
- Denominator
  - Patients with confirmed VTE receiving IV UFH therapy
- Numerator
  - All patients in the denominator who have their IV UFH therapy dosages AND platelet counts monitored according to defined parameters such as a nomogram or protocol.
- Exclusions
  - Age < 18
  - Length of stay >120 days
  - Comfort measures only
  - Enrolled in clinical trial
  - Without VTE confirmed by diagnostic testing

HITSP V1.1 2010 TN906 - Quality Measures Technical Note ED Stroke VTE, p 123-26

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VTE-5, NQF 0375: Venous Thromboembolism VTE Discharge Instructions

- Description:
  - The number of patients diagnosed with confirmed VTE that are discharged on warfarin with written discharge instructions that address specific criteria.
- Denominator
  - Patients with with a Principal Diagnosis Code or Other Diagnosis Code for VTE as defined by Value set for "Joint Commission VTE Confirmed" discharged on warfarin therapy or who received warfarin to home, to home with home health or to home hospice.
- Numerator
  - All patients in the denominator with documentation that they or their caregivers were given written discharge instructions or other educational material about warfarin that addressed all of the following:
    - Compliance issues
    - Dietary advice
    - Follow-up monitoring
    - Information about the potential for adverse drug reactions/interactions.
- Exclusions
  - Age < 18
  - Length of Stay >120 Days
  - Enrolled in Clinical Trial
  - Without warfarin prescribed at discharge
  - Without VTE confirmed by diagnostic testing

HITSP V1.1 2010 TN906 - Quality Measures Technical Note ED Stroke VTE, p 123-32

VTE-6, NQF 0376: Venous Thromboembolism Incidence Of Potentially Preventable VTE

- Description:
  - This measure assesses the number of patients diagnosed with confirmed VTE during hospitalization (not present on arrival) who did not receive VTE prophylaxis between hospital admission and the day before the VTE diagnostic testing order date.
- Denominator
  - Patients who developed confirmed VTE during hospitalization discharged with a principal diagnosis code or other diagnosis code for VTE as defined by value set for "Joint Commission VTE."
- Numerator
  - All patients in the denominator who received no VTE prophylaxis prior to the VTE diagnostic test order date
- Exclusions
  - Age < 18
  - Length of Stay >120 Days
  - Enrolled in Clinical Trial
  - Comfort measures only documented.
  - VTE Present on Arrival
  - With reasons for not administering mechanical and pharmacologic prophylaxis
  - Without VTE confirmed by diagnostic testing

HITSP V1.1 2010 TN906 - Quality Measures Technical Note ED Stroke VTE, p 133-39

Small Groups

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Outline

- Background to the Final Rule
- Financial Incentives
  - For Professionals
  - For Hospitals
- Elements of Meaningful Use
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  - For Professionals
  - For Hospitals
- **Proposed Stage II Criteria**
- Physician Engagement
- Closure

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Stage 1 to Stage 2 Meaningful Use

Eligible Professionals

Stage 1	Stage 2
15 core objectives	17 core objectives
5 of 10 menu objectives	3 of 5 menu objectives
20 total objectives	**20 total objectives**

Eligible Hospitals

Stage 1	Stage 2
14 core objectives	16 core objectives
5 of 10 menu objectives	2 of 4 menu objectives
19 total objectives	**18 total objectives**

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Stage 2 Proposed Objectives

- In general:
  - Stage 1 menu items have become core
  - Percentages have increased in many
  - Turnaround time is shorter
- Some changes to Stage 1 for 2014
  - Providing electronic copies changed to giving them online access
  - Change in vital signs decoupling height/weight from BP with h/w all ages and BP 2 => 3yo

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Stage 2 New Proposed Objectives

- All:
  - Provide online access to health information for more than 50% with more than 10% of patients actually accessing it
  - Provide summary of care document for more than 65% of transitions of care and referrals with 10% sent electronically to a site with a different vendor's EHR
- Professional:
  - More than 10% of patients send secure messages to their EP
- Hospital:
  - EMAR is implemented and used for more than 10% of medication orders

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Stage 2 Proposed Menu Objectives

- All
  - More than 40% of imaging results are accessible through Certified EHR Technology
  - Record family health history for more than 20%
- Professional:
  - Successful ongoing transmission of cancer case information
  - Successful ongoing transmission of data to a specialized registry
- Hospital:
  - E-Rx for more than 10% of discharge prescriptions

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CQM – Changes from July 28, 2010 Final Rule

2010 Final Rule

Eligible Professionals

3 core OR 3 alt. core CQMs

+

3 menu CQMs

6 total CQMs

Eligible Hospitals & CAHs

15 total CQMs

2012 Proposed Rule

Eligible Professionals

1a) 12 CQMs (≥1 per domain)

1b) 11 core + 1 menu CQMs

2) PQRS

Group Reporting

12 total CQMs

Eligible Hospitals & CAHs

24 CQMs (≥1 per domain)

24 total CQMs

Align with ONC's 2011 Edition Certification

Align with ONC's 2014 Edition Certification

CQM - 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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Certified EHR Technology

What it is today

2011 - 13

What is proposed

2014

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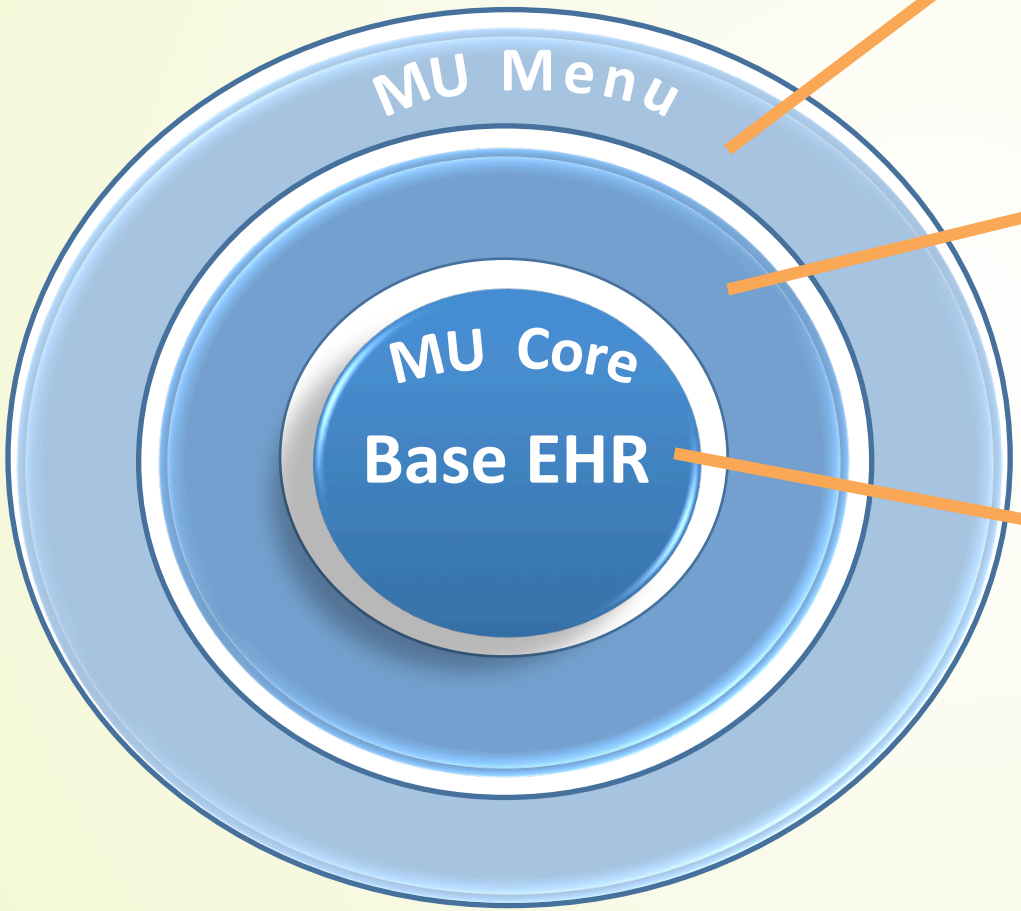
2014 Edition CEHRT



Capabilities certified for the MU menu set objectives & measures for the stage of MU they seek to achieve.

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.

Capabilities certified to meet the definition of Base EHR.

Proposed Revised 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
All EPs, EHs, and CAHs must have EHR technology certified to all applicable 2011 Edition EHR certification criteria or equivalent 2014 Edition EHR certification criteria			All EPs, EHs, and CAHs must have EHR technology (including a Base EHR) that has been certified to the 2014 Edition EHR certification criteria that would support the objectives and measures, and their ability to successfully report the CQMs, for the MU stage that they seek to achieve.

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Why is physician engagement so difficult?

- Change is difficult
- Current methods are tried and true
- They see it as benefiting the hospital and not them
- They can't type
- They see it as clerical work
- It is much faster to write an order than find it on the computer
- They believe it will slow them down
- They do not see the benefit to quality and they believe it will go down in the short run
- The clinic system is different and they do not want to learn another that they use less often

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Challenges Physicians Might Encounter

- Lots of clicks
- Frequent logins
- Different interfaces
- Difficulty finding things
- Feeling dumb
- Frustration
- Anger
- Never ending in-basket
- Simple things take longer
- Not knowing how to do things
- Despair and longing for the way things were

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Important Ingredients to Success, 1 of 2

- Leadership must believe this is the right thing to do and be unwavering
- Communicate the vision and communicate it frequently
- Physicians must recognize that the change is inevitable
- Approach it as a quality initiative
  - Incentives mean little to physicians
- Physician involvement from the start is critical

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Important Ingredients to Success, 2 of 2

- Reach out to your most resistant physician
  - "Since this is inevitable, how can we make this work for you?"
- Understand that this will be painful for them
- Make it a team effort requiring team problem solving
- Consider moving the forward in baby steps OR a dramatic change all at once
- Create short term goals and long term goals
- Be clear about what will happen if certain goals are not met
- Celebrate all your successes

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Kübler-Ross model: The Five Stages of Grief

- Denial
  - "This can't be happening, not to me!"; Maybe it will go away if I ignore it
- Anger
  - "How dare you do this to me?!" "This is just so you can make more money!"; "This is going to slow me down and patients will suffer!"
- Bargaining
  - "Can't you just let me be? I am going to retire soon."; "So how do you define CPOE? Can't I just have my nurse enter all my orders?"
- Depression
  - "When this happens, its going to screw everything up."; "I'm never going to be able to get my work done. I will be treating a computer and not a patient!"; "Being a doctor is not like it used to be."
- Acceptance
  - "I can't fight it, I may as well prepare for it."; "I may as well do what I can to make it work."

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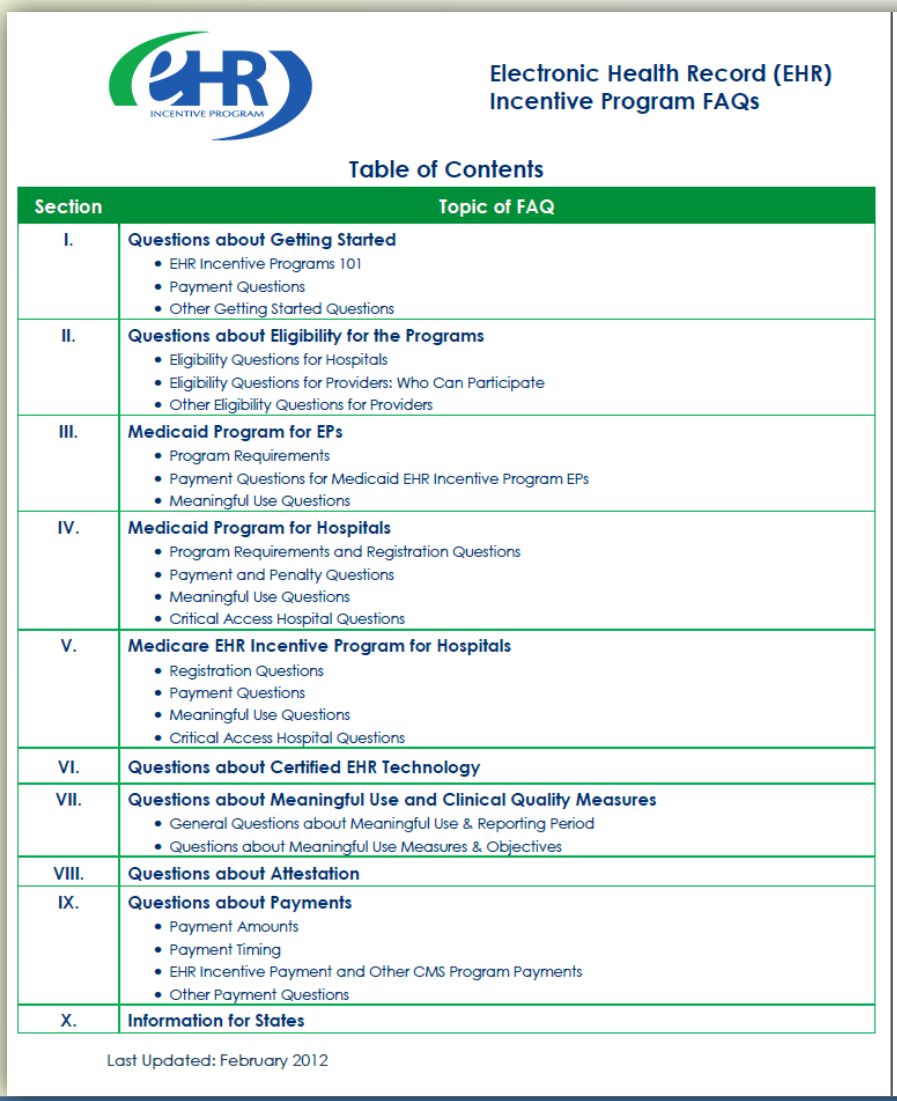
CMS Meaningful Use Website

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

Remediated and Revised CMS FAQs

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



Electronic Health Record (EHR) Incentive Program FAQs

Table of Contents

Last Updated: February 2012

I. Questions about Getting Started

EHR Incentive Programs 101

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

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

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

Date Updated: 2/17/2011
ID #10080

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

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

Date Updated: 1/3/2011
ID #9814

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

Registration for the Medicare EHR Incentive Program began on January 3, 2011 and is available for eligible professionals (EPs), eligible hospitals and critical access hospitals (CAHs) online at https://ehrincentives.cms.gov. Please note that although the Medicaid EHR Incentive Programs will begin January 3, 2011, not all states will be ready to participate on this date. Information on when registration will be available for Medicaid EHR Incentive Programs in specific States is posted at http://www.cms.gov/EHRIncentivePrograms/40_MedicaidStateInfo.asp.

Last Updated: February 2012

CMS Resources

- All Things "Meaningful Use"
  - http://www.cms.gov/EHRIncentivePrograms/
- Registration instructions :
  - http://www.cms.gov/EHRIncentivePrograms/20_RegistrationandAttestation.asp
- Meaningful Use Specification Table of Contents - Professional
  - http://www.cms.gov/EHRIncentivePrograms/Downloads/EP-MU-TOC.pdf
- Meaningful Use Specification Table of Contents - Hospital
  - http://www.cms.gov/EHRIncentivePrograms/Downloads/Hosp_CAH_MU-TOC.pdf
- Remediated and Revised FAQs (a searchable PDF)
  - http://www.cms.gov/EHRIncentivePrograms/Downloads/FAQsRemediatedandRevised.pdf
- Attestation Tools
  - http://www.cms.gov/EHRIncentivePrograms/32_Attestation.asp

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Other Resources:

- North Dakota HIT website:
  - http://www.healthit.nd.gov/
- 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/
- ONC-ATCB Certified EHRs and what modules they are certified for:
  - http://healthit.hhs.gov/chpl
- Office of the National Coordinator Health IT site:
  - http://HealthIT.gov
- ONC-ATCB Certified EHRs and what modules they are certified for:
  - http://healthit.hhs.gov/chpl

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In Review

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

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Thank you!

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