Understanding the EHR Incentive Final Rule for Eligible Professionals

Key Health Alliance

Regional Extension Assistance Center for HIT

Meaningful Use Boot Camp

October 12, 2011

Introductions

- Your name
- Where you work
- Your role at your facility
- 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). REACH is a federally subsidized non-profit entity designed to assist Hospitals and Professionals in becoming meaningful users of EHRs. He will be mentioning it in this talk.
- No other conflict of interest

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Objectives

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

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Outline

- **Background to the Final Rule**
- Financial Incentives
- Elements of Meaningful Use
- Proposed Stage II Criteria
- Quality Measures
- Knowing if Your EHR is Certified
- Registering and Attesting
- 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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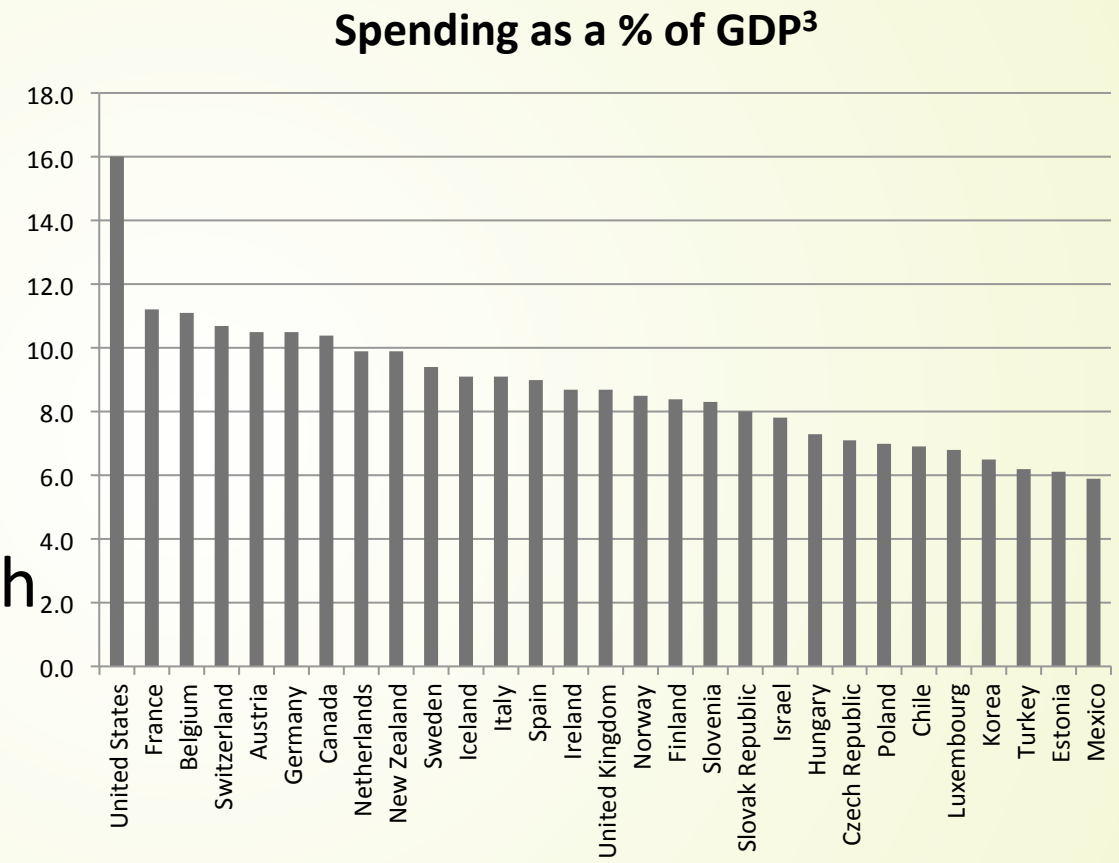
Are we getting value for our dollar? Cost vs. Quality

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



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

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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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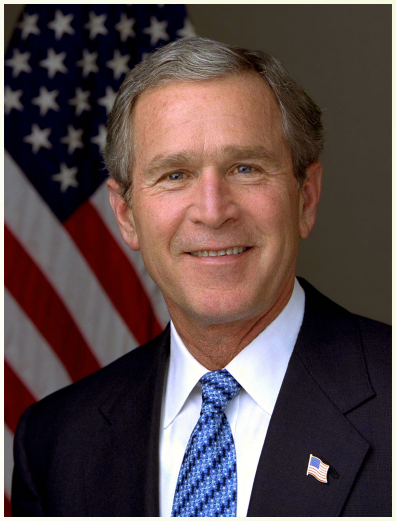
The Bi-Partisan Support:

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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Placing our Bet on HIT: The "Stimulus Package"

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

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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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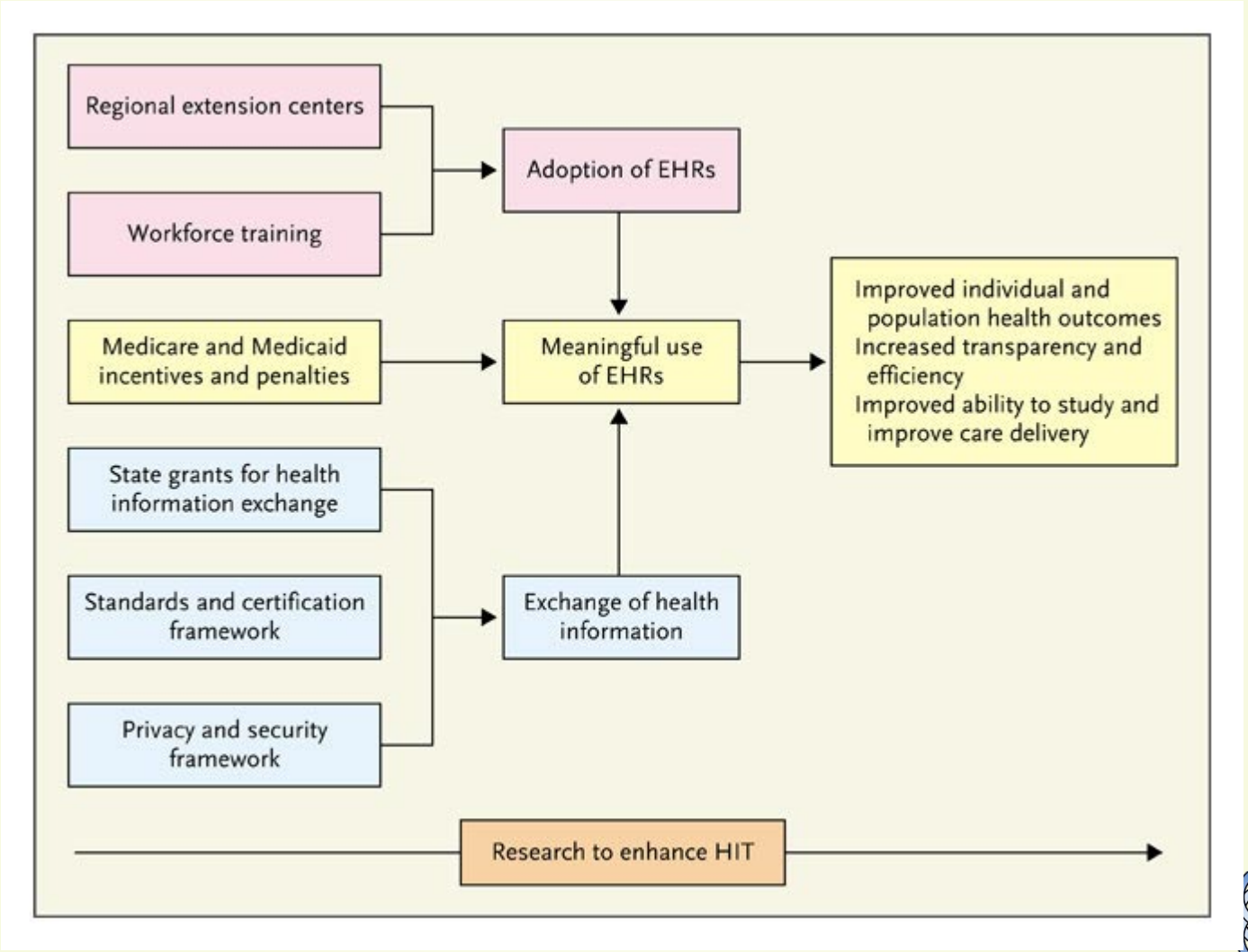
The HITECH Act's Framework



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

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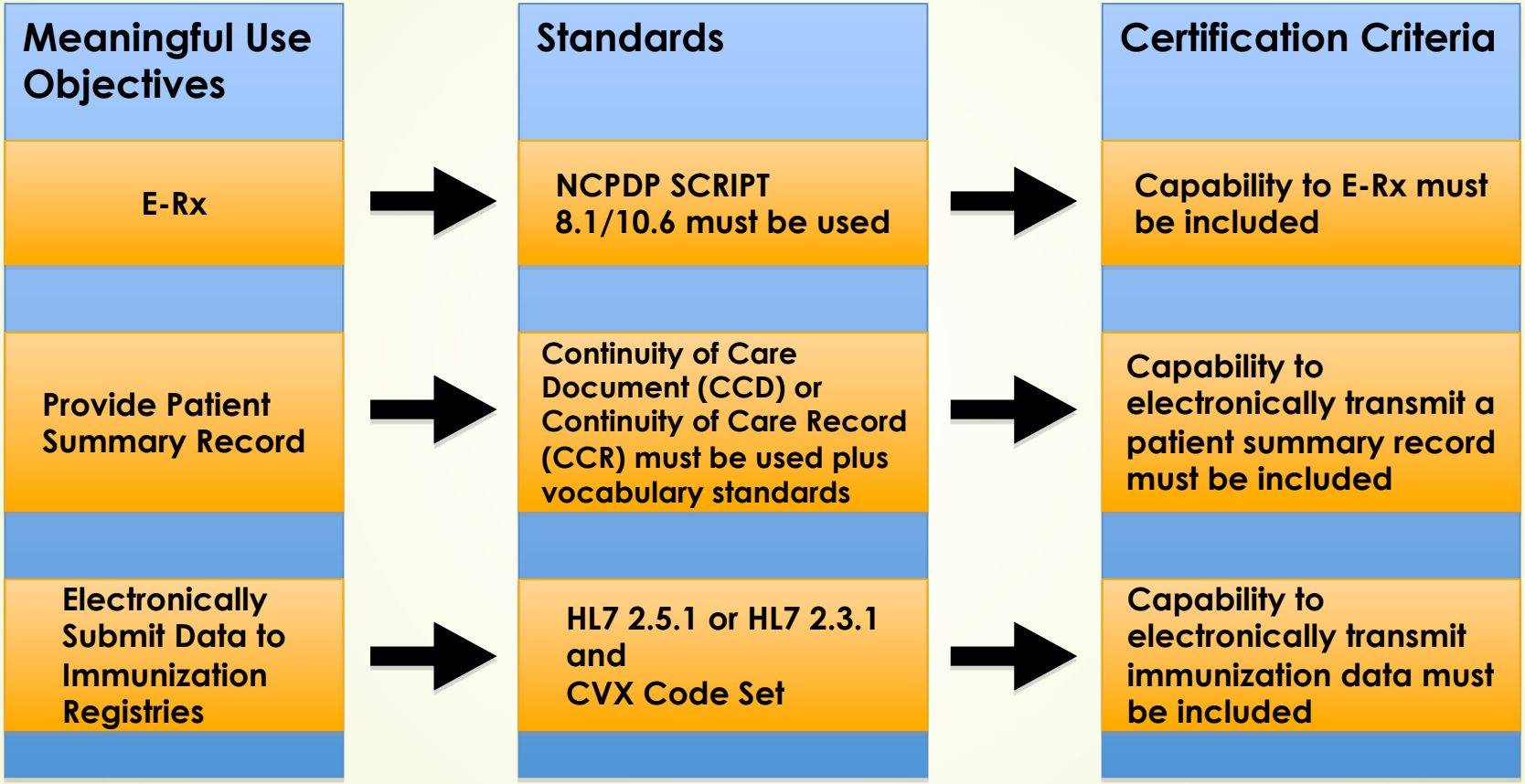
Aligning Certification and Standards



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

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Incentive Program Key Provisions

Eligibility

- Eligible Hospitals and Critical Access Hospitals can receive both Medicare and Medicaid incentives

Timeframe for Demonstrating Meaningful Use (MU):

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

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

- Eligible hospitals can receive Medicaid 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.
- This would *not* count as your first payment year for Medicare

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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

2010	2011	2012	2013	2014	2015	2016	2017	%
	Stage 1 100%	Stage 1 75%	Stage 1? 50%	Stage 2 25%	TBD	TBD	TBD	100%
		Stage 1 100%	Stage 1 75%	Stage 2 50%	TBD 25%	TBD	TBD	100%
			Stage 1 100%	Stage 1 75%	TBD 50%	TBD 25%	TBD	100%
				Stage 1 75%	TBD 50%	TBD 25%	TBD	60%
					TBD 50%	TBD 25%	TBD	30%
						TBD	TBD	0%
Penalties: Market basket update would be reduced by:					-25%	-50%	-75%	

Percentages in the cells indicate the transition factor for the Medicare Share incentive

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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	TBD	TBD	TBD	4
		Stage 1 Payment	Stage 1 Payment	Stage 2 Payment	TBD Payment	TBD	TBD	4
			Stage 1 Payment	Stage 1 Payment	TBD Payment	TBD	TBD	3
				Stage 1 Payment	TBD Payment	TBD	TBD	2
					TBD Payment	TBD	TBD	1
						TBD	TBD	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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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

		Year of Adopt, implement, Upgrade or MU Demonstration						
		2011	2012	2013	2014	2015	2016	Alt
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

Small Groups

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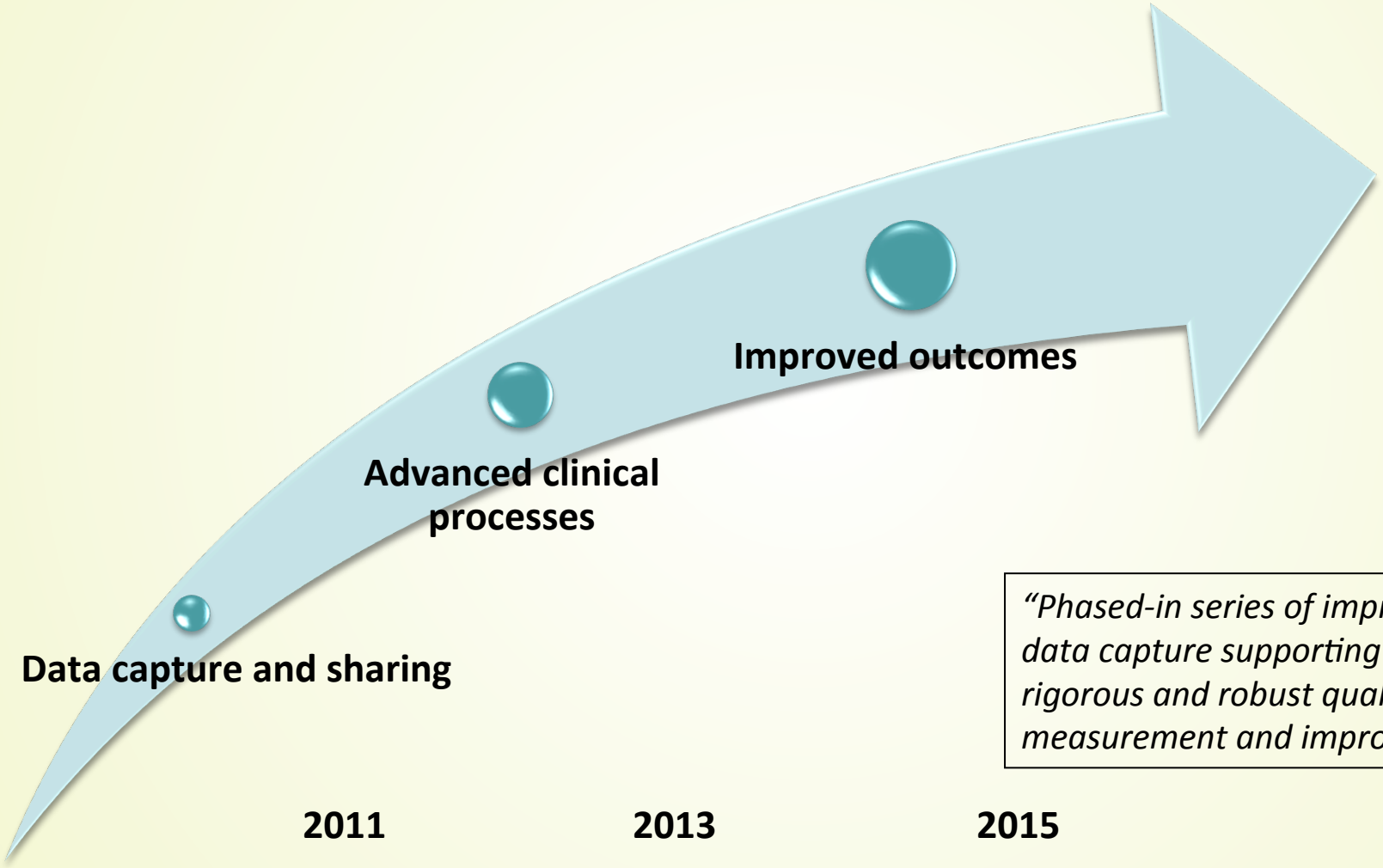
Meaningful Use Criteria

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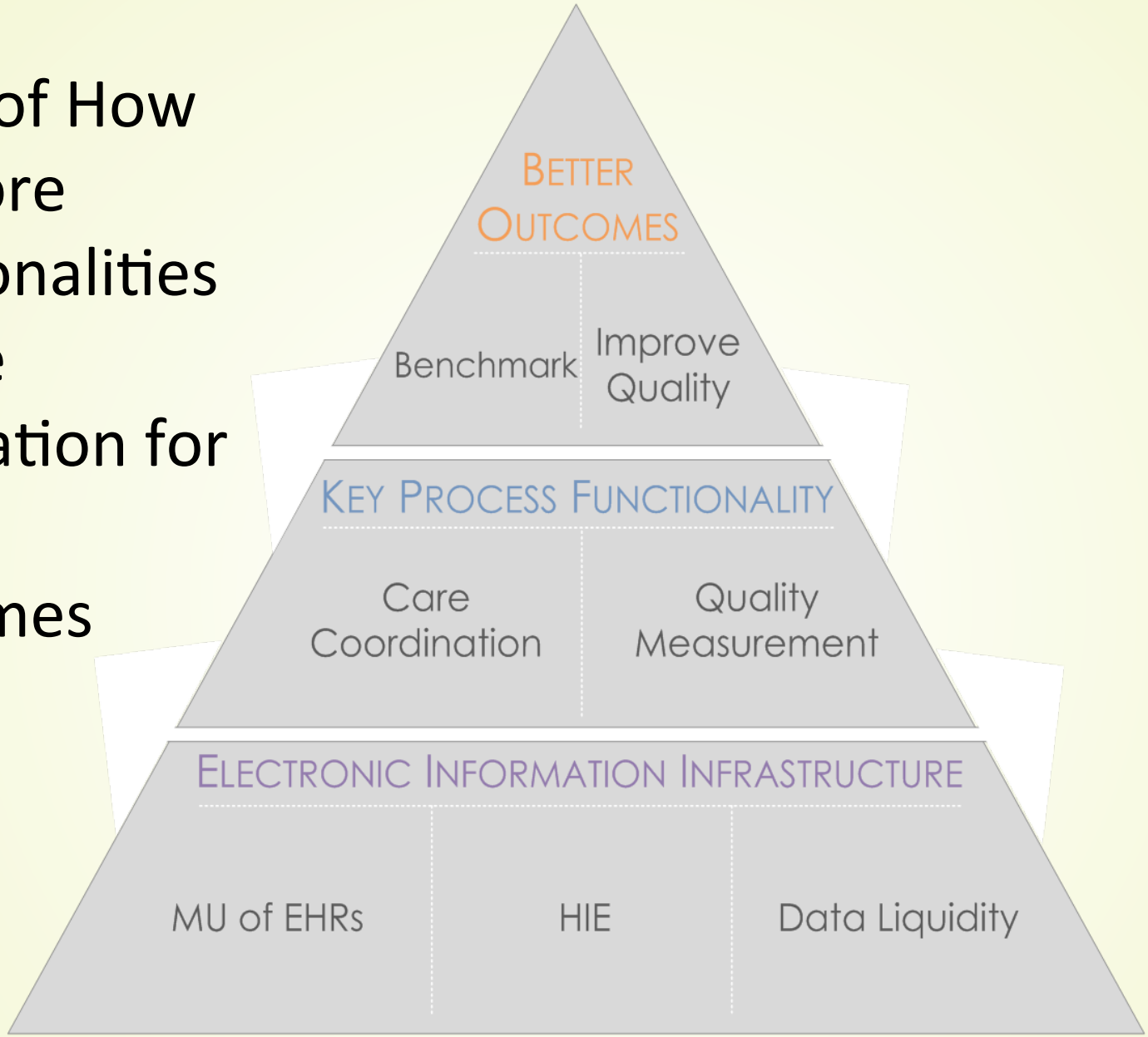
Vision of How EHR Core Functionalities Lay the Foundation for Better Outcomes



Adapted from the HIT Policy Committee Presentation June 8, 2011

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Medicaid Considerations

- State Medicaid Agencies may propose an alternative definition of meaningful use for Medicaid incentives, however...
  - State-specific MU definition would apply solely to EPs, children's hospitals and cancer hospitals
  - States cannot propose fewer or less rigorous criteria
  - States cannot propose anything that would require additional functionality beyond that of certified EHR technology
  - CMS must approve Medicaid Agencies' proposed definitions

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"Stage 1" Meaningful Use Criteria

- 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 attestation; 14 require data submission
- To meet certain objectives/measures, 80% of all patients seen during the reporting period must have certain data elements in the certified EHR technology

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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 must complete each of the core criteria unless unable to due to population served or number in the denominator. For example:
  - No patients request electronic copies of their discharge instructions or their health information

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Core Criteria (page 1 of 3)

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

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

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Core Criteria (page 2 of 3)

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

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

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Core Criteria (page 3 of 3)

	Objective	Hospital 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, discharge summary and procedures) w/i 3 business days (n/d EHR)[1]
	eDischarge Instructions	>50% of patients who request it at discharge(n/d EHR)[1]
Improve Care Coordination	Exchange with providers[2]	Capability of electronic exchange of key information (Ex: d/c summary, procedures, prob list, med list, allergies, test results[3]). One test per measurement period (y/n)
Privacy/security protections for PHI	Protect Patient Personal Health Information	Conduct or review a security risk analysis per 45 CFR 164.308 (a)(1) and correct deficiencies (y/n)

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

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Menu Criteria

- 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 is unable to complete one of the menu items due to scope of practice, they may still defer 5 menu items
- States can seek CMS prior approval to require 4 MU criteria be core for their Medicaid providers:
  - Generate lists of patients by specific condition
  - Reporting to immunization registries, reportable lab results, and syndromic surveillance

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Menu Criteria (page 1 of 2)

	Objective	Hospital 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	>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 EHR)[1]
	Patient Lists[3]	Generate at least one pt list based on a specific condition (y/n)
Engage Patients and Families in Their Health Care	Patient Ed	>10% patients seen provided with educational resources identified with the EHR (n/d all)[2]

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

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Menu Criteria (page 2 of 2)

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

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

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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/Hosp_CAH_MU-TOC.pdf
- Updated by CMS to account for any corrections or changes
- Can be text-word searched

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Example of e-Exchange of Clinical Info

Eligible Hospital and Critical Access Hospital Meaningful Use Core Measures Measure 13 of 14

Stage 1

Last Updated: June 8, 2011

Electronic Exchange of Clinical Information	
Objective	Capability to exchange key clinical information (for example, problem list, medication list, medication allergies, and diagnostic test results), among providers of care and patient authorized entities electronically.
Measure	Performed at least one test of certified EHR technology's capacity to electronically exchange key clinical information.
Exclusion	No exclusion.

Table of Contents

- Definition of Terms
- Attestation Requirements
- Additional Information

Definition of Terms

Diagnostic Test Results – All data needed to diagnose and treat disease. Examples include, but are not limited to, blood tests, microbiology, urinalysis, pathology tests, radiology, cardiac imaging, nuclear medicine tests, and pulmonary function tests.

Different Legal Entities – A separate legal entity is an entity that has its own separate legal existence. Indications that two entities are legally separate would include (1) they are each separately incorporated; (2) they have separate Boards of Directors; and (3) neither entity is owned or controlled by the other.

Distinct Certified EHR Technology – Each instance of certified EHR technology must be able to be certified and operate independently from all the others in order to be distinct. Separate instances of certified EHR technology that must link to a common database in order to gain certification would not be considered distinct. However, instances of certified EHR technology that link to a common, uncertified system or component would be considered distinct. Instances of certified EHR technology can be from the same vendor and still be considered distinct.

Exchange – Clinical information must be sent between different legal entities with distinct certified EHR technology and not between organizations that share a certified EHR technology. Distinct certified EHR technologies are those that can achieve certification and operate independently of other certified EHR technologies. The exchange of information requires that the eligible hospital or critical access hospital must use the standards of certified EHR technology as specified by the Office of the National Coordinator for Health IT, not the capabilities of uncertified or other vendor-specific alternative methods for exchanging clinical information.

Patient Authorized Entities – Any individual or organization to which the patient has granted access to their clinical information. Examples could include an insurance company that covers the patient, an entity facilitating health information exchange among providers, or a personal health record vendor identified by the patient. A patient would have to affirmatively grant access to these entities.

Attestation Requirements

YES/NO

Eligible hospitals and CAHs must attest YES to having performed at least one test of certified EHR technology's capacity to electronically exchange key clinical information prior to the end of the EHR reporting period to meet this measure.

Additional Information

- The test of electronic exchange of key clinical information must involve the transfer of information to another provider of care with distinct certified EHR technology or other system capable of receiving the information. Simulated transfers of information are not acceptable to satisfy this objective.
- The transmission of actual patient information is not required for the purposes of a test. The use of test information about a fictional patient that would be identical in form to what would be sent about an actual patient would satisfy this objective.
- When the clinical information is available in a structured format it should be transferred in a structured format. However, if the information is unavailable in a structured format, the transmission of unstructured data is permissible.
- Providers can use their clinical judgment to identify what clinical information is considered key clinical information for purposes of exchanging clinical information about a patient at a particular time with other providers of care. A minimum set of information is identified in the HIT Standards and Criteria rule at 45 CFR 170.306(f): diagnostic test results, problem list, medication list, medication allergy list.
- An eligible hospital or CAH should test their ability to send the minimum information set in the HIT Standards and Criteria rule at 45 CFR 170.306(f). If the eligible hospital or CAH continues to exchange information beyond the initial test, then the provider may decide what information should be exchanged on a case-by-case basis.
- Eligible hospitals and CAHs must test their ability to electronically exchange key clinical information at least once prior to the end of the EHR reporting period. Testing may also occur prior to the beginning of the EHR reporting period. Every payment year requires its own, unique test.
- An unsuccessful test of electronic exchange of key clinical information will be considered valid for meeting the measure of this objective.

Additional Information

- #10638 - For the meaningful use objective of "capability to exchange key clinical information," does exchange of electronic information using physical media, such as USB, CD-ROM, or other formats, meet the measure of this objective?

Testing Criteria

Criteria #	Certification Criteria	Test Method	Date Published
§170.302 (a)	**Drug-drug, drug-allergy interaction checks**	Test Procedure:	09/24/2010
§170.302 (b)	**Drug formulary checks**	Test Procedure:	09/24/2010
§170.302 (c)	**Maintain up-to-date problem list**	Test Procedure:	09/24/2010
		Errata:	12/03/2010
§170.302 (d)	**Maintain active medication list**	Test Procedure:	09/24/2010
		Errata:	12/03/2010
§170.302 (e)	**Maintain active medication allergy list**	Test Procedure:	09/24/2010
§170.302 (f)(1)	**Vital signs**	Test Procedure:	09/24/2010
		Errata:	12/03/2010
§170.302 (f)(2)	**Calculate body mass index**	Test Procedure:	09/24/2010
§170.302 (f)(3)	**Plot and display growth charts**	Test Procedure:	09/24/2010
§170.302 (g)	**Smoking status**	Test Procedure:	09/24/2010
§170.302 (h)	**Incorporate laboratory test results**	Test Procedure:	09/24/2010
		Errata:	12/03/2010
§170.302 (i)	**Generate patient lists**	Test Procedure:	09/24/2010
§170.302 (j)	**Medication reconciliation**	Test Procedure:	09/24/2010
§170.302 (k)	**Submission to immunization registries**	Test Procedure:	09/24/2010
		Errata:	12/03/2010

- Testing criteria for each of these modules (criteria) can be found at:
  - http://healthcare.nist.gov/use_testing/effective_requirements.html
- Techies only need to look at this

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Criteria:

Core:

All Patients:

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

EHR Patients:

- CPOE
- Vital signs
- Smoking status
- E-copy of their health information
- E-copy of discharge instructions

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:

- Provide patient-specific education resources

EHR Patients:

- Advanced directives
- Labs as structured data
- 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. *
- 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

- Background to the Final Rule
- Financial Incentives
- Elements of Meaningful Use
- **Proposed Stage II Criteria**
- Quality Measures
- Knowing if Your EHR is Certified
- Registering and Attesting
- Physician Engagement
- Closure

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Core Criteria (page 1 of 3)

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

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

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Core Criteria (page 2 of 3)

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

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

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Core Criteria (page 3 of 3)

Objective	Ambulatory Measure	Proposed Stage II
eHealth summary	>50% of patients who request it (incl: test results, prob list, med list, med allergies, discharge summary and procedures) w/i 3 business days (n/d EHR)[1]	Moved into another criteria (See eAccess)
eDischarge Instructions	>50% of patients who request it at discharge(n/d EHR)[1]	>25 patients
Exchange with providers[2]	Capability of electronic exchange of key information (Ex: d/c summary, procedures, prob list, med list, allergies, test results[3]). One test per measurement period (y/n)	Substituted
Protect Patient Personal Health Information	Conduct or review a security risk analysis per 45 CFR 164.308 (a)(1) and correct deficiencies (y/n)	No change

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

Menu Criteria (page 1 of 2)

Objective	Ambulatory Measure	Proposed Stage II
Formularies	Implement drug formulary checks with at least one internal or external formulary (y/n)	May use a generic sub formulary Moved to Core
Advanced Directives	>50% of ≥ 65yo admitted indicate advanced directive recorded (n/d EHR non ED)	…and access to a copy if it exists Moved to Core
Lab Results	>40% of labs with numeric or +/- result in chart as structured data (n/d EHR)[1]	Moved to Core
Patient Lists[2]	Generate at least one pt lists based on a specific condition (y/n)	Multiple lists Moved to Core
eAccess	>10% patients seen with electronic access to lab results, prob lists, med list, med allergies w/i 4 business days of it being updated in the EHR (n/d all)[1]	>10% of patients access to longitudinal record w/i 24 hrs , Electronic access counts. Moved to Core
Patient Ed	>10% patients seen provided with ed resources identified with the EHR (n/d all)[1]	Removed "If appropriate" Moved to Core

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

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Menu Criteria (page 2 of 2)

Objective	Ambulatory Measure	Proposed Stage II
Medication reconciliation	>50% of transitions of care or a relevant encounter (n/d EHR)	Moved to Core
Summary care record	>50% of referrals and transitions of care[1] (n/d EHR)	>10% of all discharges have summary and care plan sent electronically to EP or post-acute care facility. Moved to Core
Immunization Records	≥ 1 test of submission to state immunization registry (unless no registries are capable) with continued submission if successful (y/n)	Success required Moved to Core
Reportable Labs	≥ 1 test of submission to public health (unless no ph agency is capable) with continued submission if successful (y/n)	Success required Moved to Core
Syndromic Surveillance	≥ 1 test of submission to public health (unless no ph agency is capable) with continued submission if successful (y/n)	Success required Moved to Core

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Proposed New Stage II Criteria

Objective	Hospital Measure
ePrescribe	>10% of hospital discharge medication orders transmitted as eRx
Lab Results	Hospital labs send (directly or indirectly) structured electronic clinical lab results to outpatient providers for ≥ 40% of electronic orders received
Progress Notes	30% of EH patient days have at least one electronic note by a physician, NP, or PA. Scanned notes do not qualify
Med Tracking	EH medication orders automatically tracked via eMAR; (in-use in at least one hospital ward/unit) "5 rights"
Admission Info	10% of patients/families view and have ability to download information about a hospital admission. Available for all patients within 36 hours of the encounter
Care Team	List of care team members (including PCP, if available) available for 10% of patients via electronic exchange; (May be unstructured data for stage 2)

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Lunch!

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Outline

- Background to the Final Rule
- Financial Incentives for Hospitals
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Quality Measures

- Relate to healthcare quality aims such as effective, safe, efficient, patient-centered, equitable, and timely care.
- Eligible hospitals will be required to submit data on all 15 measures
- Some hospitals, such as children's hospitals, will have zero in the denominator of some measures

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Reporting of Clinical Quality Measures

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

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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

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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

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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

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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

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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

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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

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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

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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

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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

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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

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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

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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

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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

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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

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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

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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

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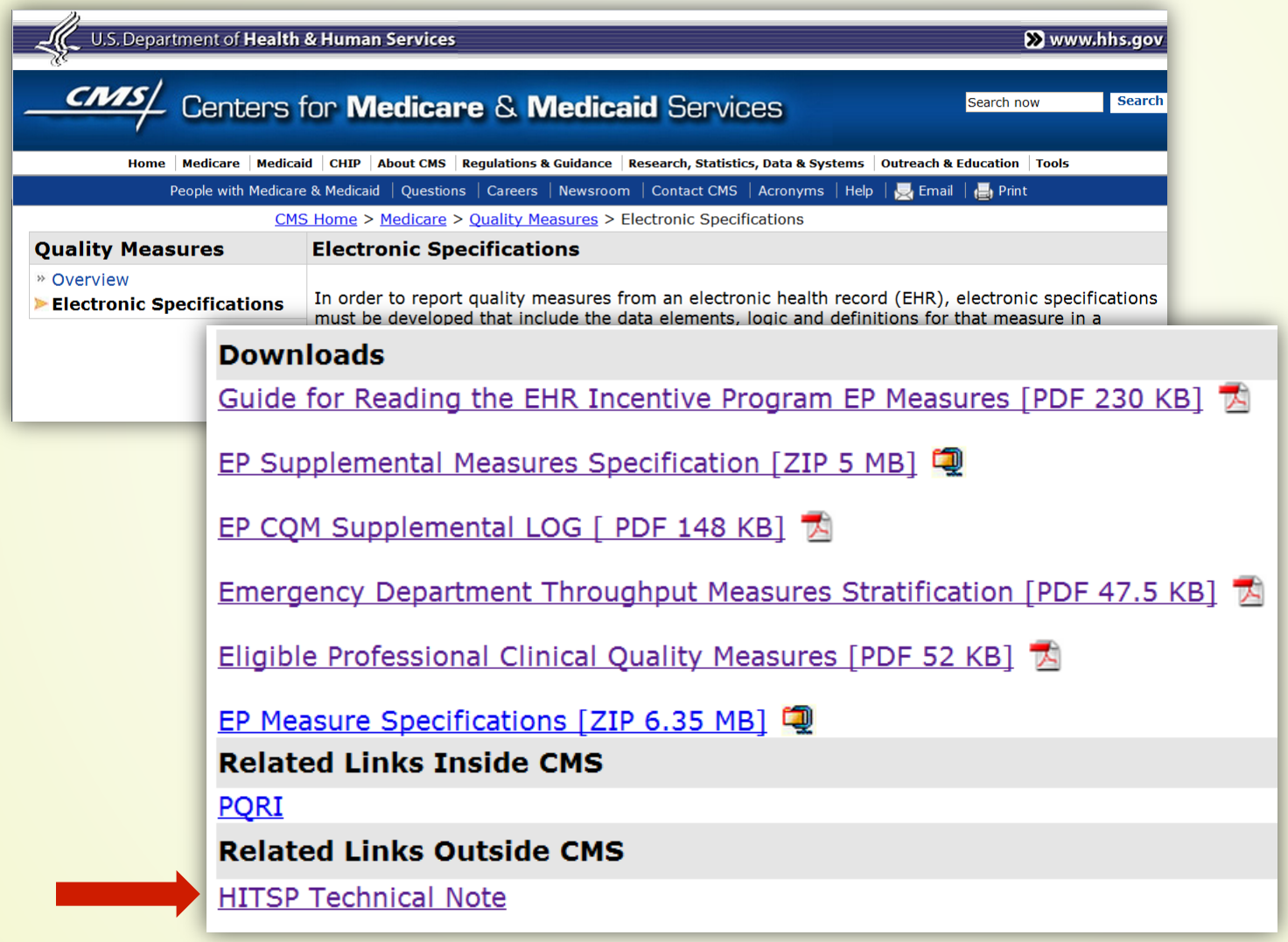
Hospital QM Specifications

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



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Hospital Specification Guide

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Federal Agencies must use the Recognized Interoperability Standards that have been harmonized by HITSP.

HITSP Member Workspace (password required)

Public Review and Comment

Reference Documents

- Acronyms
- AHIC Use Cases
- Conventions (naming and numbering)
- Glossary
- Harmonization Framework
- Interoperability Specifications Overview

HITSP free webinar series on U.S. healthcare interoperability

Technical Note

TN 906 - TN906 - Quality Measures Technical Note

This document provides several examples of quality measures specified based on information available within electronic data sources as specified using the HITSP IS06 Quality Interoperability Specification. The examples include measures in the Stroke, Venous Thromboembolism and Emergency Department sets of quality measures provided to HITSP by CMS. These examples includes a description of the measures, the sets of data elements needed to address each measure (including any derived data elements), the associated value sets, the eMeasure representation, and the QRDA representation required to report performance based on these measures. Note that QRDA is the HL7 Quality Reporting Document Architecture that enables providers to use the same data constructs developed for information exchange to report on quality measures directly out of the EHR. This document also provides an example of the XML emeasure populated with sample data from the examples. This document is intended to exemplify the use of the HITSP specifications in specifying and reporting on a quality measure. This document is also intended to serve as guidance for the implementation of the example measures using the HITSP standards.

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Construct	Title / Version	Referenced by	Status	Document Access
TN 906	TN906 - Quality Measures Technical Note Version:1.0		Released (Panel Approved)	DOWNLOAD
TN 906	TN906 - Quality Measures Technical Note Version:1.1		Released (Panel Approved)	DOWNLOAD

NOTE: As a part of its work, the Technical Committee undertook the definition of 16 Quality Measures. These measures are encoded according to the HL7 HQMF as specified by the HITSP C106 Measurement Criteria Component. The .xml files for these can be found here.

Enclosed are .xml files along with a simple style sheet in order to view in a browser. To open and read Quality Measures .xml files:
1. Download HITSP_Quality_Measures_20100430.zip file.
2. Create a new folder on your hard drive.
3. Extract the entire contents of the HITSP_Quality_Measures_20100430.zip file into the new folder.
4. Open the new folder.
5. Double click on a file to open and read the individual .xml files within a browser.

Please note that to view the native .xml, we suggest you open the files in a text editor such as Text Pad. The simple style sheet allows you to open the .xml files within a browser such as Internet Explorer or Firefox, however, not all browsers behave the same way with .xml style sheets.

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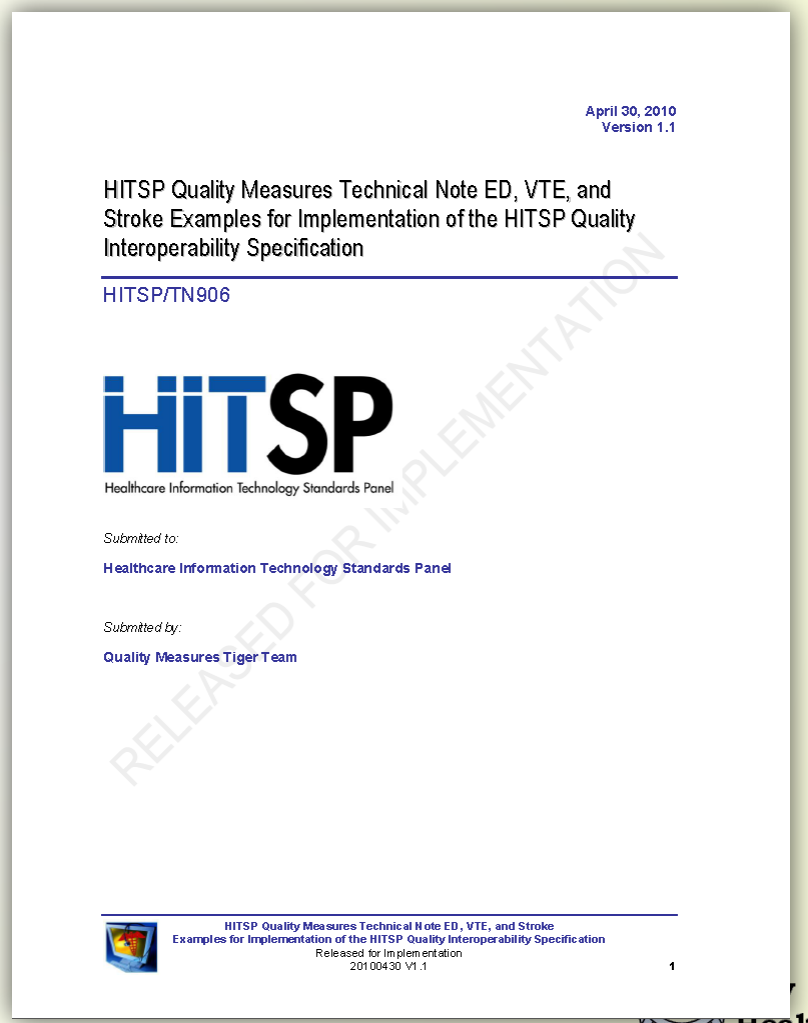


April 30, 2010
Version 1.1

HITSP Quality Measures Technical Note ED, VTE, and Stroke Examples for Implementation of the HITSP Quality Interoperability Specification

HITSP/TN906

HITSP Healthcare Information Technology Standards Panel

Submitted to:

Healthcare Information Technology Standards Panel

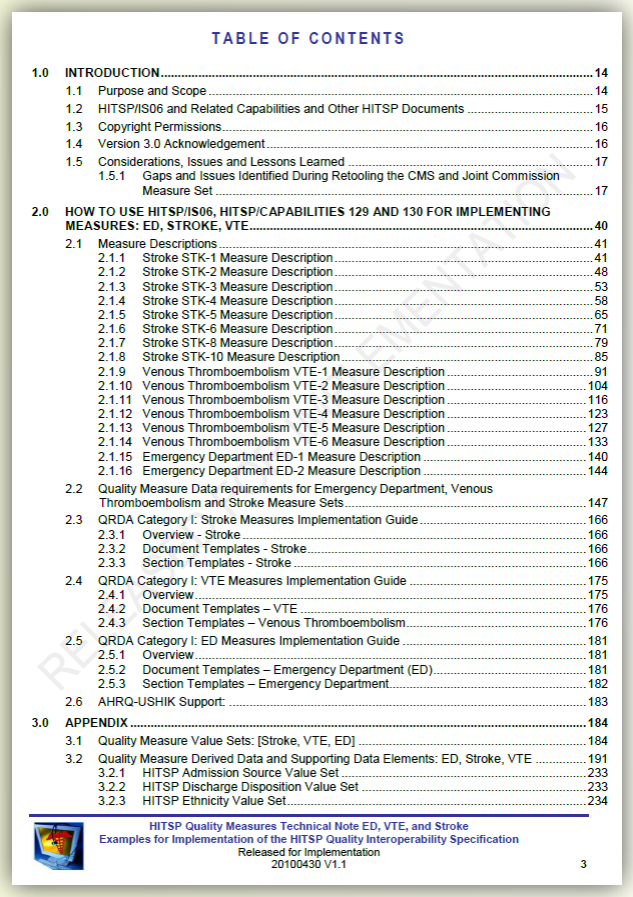
Submitted by:

Quality Measures Tiger Team

RELEASED FOR IMPLEMENTATION

Health Alliance
Regional Extension Assistance Center for HIT

Measure Specifications



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2.1 MEASURE DESCRIPTIONS

2.1.1 STROKE STK-1 MEASURE DESCRIPTION

Table 2-1 STK-1 Venous Thromboembolism (VTE) Prophylaxis

Reference	Kucher N, Koo S, Quiroz R, Cooper JM, et al. (2005). Electronic alerts to prevent venous thromboembolism among hospitalized patients. New England Journal of Medicine, 352(10), 969-1036
Reference	Michota FA. Venous thromboembolism prophylaxis in medical patients. Curr Opin Cardiol. 2004 Nov;19(6):570-4

"Joint Commission Stroke Value Set"
Denominator Exclusions:
- Patients with (Age < 18)

Population

/*** IF Patient Class of Inpatient Encounter THEN 'Y' ELSE 'N' */

/** IF "Clinical Trial" */

)
OR
(
((Diagnoses CONTAINS (Joint Commission Reason for no VTE Prophylaxis - Pharmacologic) AND (AdmitDate - ProblemDate<=1 AND >=0)) OR
/* VTE Prophylaxis Medication Declined */
(Medications Administered CONTAINS ValueSet (Joint Commission VTE Prophylaxis Medications) AND Tense CONTAINS ValueSet (Joint Commission Tense ActMood Intent) AND negation IND ='True' AND Reason (Contains (ValueSet (Joint Commission Patient Reason) OR ValueSet (Joint Commission Medical Reason)) AND (AdmitDate - Medications Administered Date/Time <=1 AND >=0))
)
AND
((Diagnoses CONTAINS ValueSet (Joint Commission Reason for no VTE Prophylaxis – Mechanical) AND (AdmitDate - Diagnosis Date/Time<=1 AND >=0)) OR
/* VTE Prophylaxis -Mechanical Intervention Procedure Declined */
- (
- (Procedure Ordered CONTAINS ValueSet (Joint Commission VTE Prophylaxis – Application of Mechanical Device)
- AND Tense CONTAINS ValueSet (Joint Commission Tense ActMood Intent) AND negation IND ='True' AND Reason (Contains (ValueSet (Joint Commission Patient Reason) OR ValueSet (Joint Commission Medical Reason)))

OR (Procedure Performed CONTAINS ValueSet (Joint Commission VTE Prophylaxis – Application of Mechanical Device) AND Tense CONTAINS ValueSet (Joint Commission Tense ActMood Intent) AND negation IND ='True' AND Reason (Contains (ValueSet (Joint Commission Patient Reason) OR ValueSet (Joint Commission Medical Reason))) AND (AdmitDate - Procedure Start Date<=1 AND >=0))
)
)

THEN 'Y' ELSE 'N'

And then there the codes that must be grouped together… Anti-thrombotics

Table 3-231 Joint Commission Stroke Antithrombolytic Medications Value Set Definition

Value	Display Name	Definition
307754	Aluminum Hydroxide 300 MG /Aspirin 325 MG /Magnesium Hydroxide 300 MG Oral Tablet	Not Available
307765	Aluminum Hydroxide 75 MG /Aspirin 325 MG /Calcium Carbonate 75 MG /Magnesium Hydroxide 75 MG Oral Tablet	
307766	Aluminum Hydroxide 75 MG /Aspirin 325 MG /Magnesium Hydroxide 75 MG Oral Tablet	
198461	Aspirin 120 MG Rectal Suppository	
198462	Aspirin 125 MG Rectal Suppository	
238144	Aspirin 130 MG Rectal Suppository	
308403	Aspirin 165 MG Enteric Coated Tablet	
308402	Aspirin 165 MG Oral Tablet	
238145	Aspirin 195 MG Rectal Suppository	
198463	Aspirin 200 MG Rectal Suppository	
199281	Aspirin 300 MG Oral Tablet	
198464	Aspirin 300 MG Rectal Suppository	
198467	Aspirin 325 MG Enteric Coated Tablet	
198466	Aspirin 325 MG Oral Capsule	

Value	Display Name	Definition
212033	Aspirin 325 MG Oral Tablet	
198468	Aspirin 325 MG Rectal Suppository	
198470	Aspirin 486 MG Oral Tablet	
308409	Aspirin 500 MG Enteric Coated Tablet	
198471	Aspirin 500 MG Oral Tablet	
198472	Aspirin 60 MG Rectal Suppository	
198473	Aspirin 600 MG Rectal Suppository	
308413	Aspirin 65 MG Chewable Tablet	
313807	Aspirin 65 MG Rectal Suppository	
308411	Aspirin 650 MG Enteric Coated Tablet	
308412	Aspirin 650 MG Extended Release Tablet	
247137	Aspirin 650 MG Oral Powder	
198475	Aspirin 650 MG Oral Tablet	
198474	Aspirin 650 MG Rectal Suppository	
308414	Aspirin 75 MG Chewable Tablet	
308415	Aspirin 800 MG Extended Release Capsule	
197374	Aspirin 800 MG Extended Release Tablet	
318272	Aspirin 81 MG Chewable Tablet	
308416	Aspirin 81 MG Enteric Coated Tablet	
247138	Aspirin 850 MG Oral Powder	
308417	Aspirin 975 MG Enteric Coated Tablet	
308418	Aspirin 975 MG Extended Release Tablet	
359458	12 HR Aspirin 25 MG /Dipyridamole 200 MG Extended Release Capsule	
308405	Aspirin 25 MG /Dipyridamole 200 MG Extended Release Capsule	
259081	Aspirin 25 MG /Dipyridamole 200 MG Oral Capsule	
403870	Aspirin 325 MG /Pravastatin 20 MG Oral Tablet	
465418	Aspirin 325 MG /Pravastatin 40 MG Oral Tablet	
403869	Aspirin 81 MG /Pravastatin 20 MG Oral Tablet	
403873	Aspirin 81 MG /Pravastatin 80 MG Oral Tablet	
762668	{30 (Aspirin 325 MG Oral Tablet) /30 (Pravastatin 20 MG Oral Tablet) } Pack	
762664	{30 (Aspirin 325 MG Oral Tablet) /30 (Pravastatin 40 MG Oral Tablet) } Pack	
762899	{30 (Aspirin 325 MG Oral Tablet) /30 (Pravastatin 80 MG Oral Tablet) } Pack	
762901	{30 (Aspirin 81 MG Oral Tablet) /30 (Pravastatin 20 MG Oral Tablet) } Pack	
762903	{30 (Aspirin 81 MG Oral Tablet) /30 (Pravastatin 40 MG Oral Tablet) } Pack	
762905	{30 (Aspirin 81 MG Oral Tablet) /30 (Pravastatin 80 MG Oral Tablet) } Pack	
308351	argatroban 100 MG/ML Injectable Solution	
749196	clopidogrel 300 MG Oral Tablet	
309362	clopidogrel 75 MG Oral Tablet	
727384	0.2 ML Dalteparin 12500 UNT/ML Prefilled Syringe	
727718	0.2 ML Dalteparin 25000 UNT/ML Prefilled Syringe	
727719	0.3 ML Dalteparin 2500 UNT/ML Prefilled Syringe	
792060	0.3 ML Dalteparin 25000 MG/ML Prefilled Syringe	
827000	0.3 ML Dalteparin 25000 UNT/ML Prefilled Syringe	
727838	0.4 ML Dalteparin 25000 UNT/ML Prefilled Syringe	

Value	Display Name	Definition
727859	0.5 ML Dalteparin 25000 UNT/ML Prefilled Syringe	
727861	0.6 ML Dalteparin 25000 UNT/ML Prefilled Syringe	
727860	0.72 ML Dalteparin 25000 UNT/ML Prefilled Syringe	
727383	1 ML Dalteparin 10000 UNT/ML Prefilled Syringe	
562130	Dalteparin 10000 UNT/ML Injectable Solution	
248140	Dalteparin 12500 UNT/ML Injectable Solution	
248379	Dalteparin 2500 UNT/ML Injectable Solution	
562550	Dalteparin 25000 UNT/ML Injectable Solution	
543266	Dalteparin 250000 UNT/ML Injectable Solution	
645889	Dalteparin 5000 UNT/ML Injectable Solution	
645893	Dalteparin 7500 UNT/ML Injectable Solution	
727730	0.2 ML Enoxaparin 100 MG/ML Prefilled Syringe	
854228	0.3 ML Enoxaparin sodium 100 MG/ML Prefilled Syringe	
854235	0.4 ML Enoxaparin sodium 100 MG/ML Prefilled Syringe	
854238	0.6 ML Enoxaparin sodium 100 MG/ML Prefilled Syringe	
854241	0.8 ML Enoxaparin sodium 100 MG/ML Prefilled Syringe	
854248	1 ML Enoxaparin sodium 100 MG/ML Prefilled Syringe	
854252	1 ML Enoxaparin sodium 150 MG/ML Prefilled Syringe	
854255	Enoxaparin sodium 100 MG/ML Injectable Solution	
854245	0.8 ML Enoxaparin sodium 150 MG/ML Prefilled Syringe	
854258	Enoxaparin sodium 150 MG/ML Injectable Solution	
727565	0.4 ML fondaparinux 12.5 MG/ML Prefilled Syringe	
861363	0.4 ML Fondaparinux sodium 12.5 MG/ML Prefilled Syringe	
727563	0.5 ML fondaparinux 5 MG/ML Prefilled Syringe	
727567	0.6 ML fondaparinux 12.5 MG/ML Prefilled Syringe	
727560	0.8 ML fondaparinux 12.5 MG/ML Prefilled Syringe	
616862	fondaparinux 12.5 MG/ML Injectable Solution	
349308	fondaparinux 5 MG/ML Injectable Solution	
861356	0.8 ML Fondaparinux sodium 12.5 MG/ML Prefilled Syringe	
545076	Fondaparinux sodium 12.5 MG/ML Injectable Solution	
861360	0.5 ML Fondaparinux sodium 5 MG/ML Prefilled Syringe	
861365	0.6 ML Fondaparinux sodium 12.5 MG/ML Prefilled Syringe	
200322	lepirudin 50 MG/ML Injectable Solution	
849701	0.2 ML Heparin sodium 25000 UNT/ML Prefilled Syringe	
829888	0.25 ML Heparin sodium 10000 UNT/ML Prefilled Syringe	
829886	0.5 ML Heparin sodium 10000 UNT/ML Prefilled Syringe	
829885	0.75 ML Heparin sodium 10000 UNT/ML Prefilled Syringe	
849704	1 ML Heparin sodium 1000 UNT/ML Prefilled Syringe	
829884	1 ML Heparin sodium 10000 UNT/ML Prefilled Syringe	
848335	Heparin sodium 100 UNT/ML Injectable Solution	
849710	Heparin sodium 1000 UNT/ML Injectable Solution	
830698	Heparin sodium 10000 UNT/ML Injectable Solution	
849712	Heparin sodium 12500 UNT/ML Injectable Solution	
849714	Heparin sodium 15000 UNT/ML Injectable Solution	

Value	Display Name	Definition
849718	Heparin sodium 2000 UNT/ML Injectable Solution	
849722	Heparin sodium 20000 UNT/ML Injectable Solution	
849724	Heparin sodium 250 UNT/ML Injectable Solution	
849726	Heparin sodium 2500 UNT/ML Injectable Solution	
849759	Heparin sodium 25000 UNT/ML Injectable Solution	
849762	Heparin sodium 3000 UNT/ML Injectable Solution	
849764	Heparin sodium 40 UNT/ML Injectable Solution	
849766	Heparin sodium 4000 UNT/ML Injectable Solution	
849768	Heparin sodium 40000 UNT/ML Injectable Solution	
849770	Heparin sodium 50 UNT/ML Injectable Solution	
849776	Heparin sodium 5000 UNT/ML Injectable Solution	
849779	Heparin sodium 6000 UNT/ML Injectable Solution	
849783	Heparin sodium 7500 UNT/ML Injectable Solution	
313406	Ticlopidine 250 MG Oral Tablet	
351111	tinzaparin 10000 UNT/ML Injectable Solution	
313410	tinzaparin 20000 UNT/ML Injectable Solution	
313735	Warfarin 2 MG Oral Tablet	
855350	Warfarin Sodium 0.5 MG Oral Tablet	
855288	Warfarin Sodium 1 MG Oral Tablet	
855296	Warfarin Sodium 10 MG Oral Tablet	
855302	Warfarin Sodium 2 MG Oral Tablet	
855308	Warfarin Sodium 2 MG/ML Injectable Solution	
855312	Warfarin Sodium 2.5 MG Oral Tablet	
855318	Warfarin Sodium 3 MG Oral Tablet	
855324	Warfarin Sodium 4 MG Oral Tablet	
855332	Warfarin Sodium 5 MG Oral Tablet	
855338	Warfarin Sodium 6 MG Oral Tablet	
855344	Warfarin Sodium 7.5 MG Oral Tablet	

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Outline

- Background to the Final Rule
- Financial Incentives for Hospitals
- Elements of Meaningful Use
- Proposed Stage II Criteria
- Quality Measures
- **Knowing if Your EHR is Certified**
- Registering and Attesting
- Physician Engagement
- Closure

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How do you know if your EHR is Certified?

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

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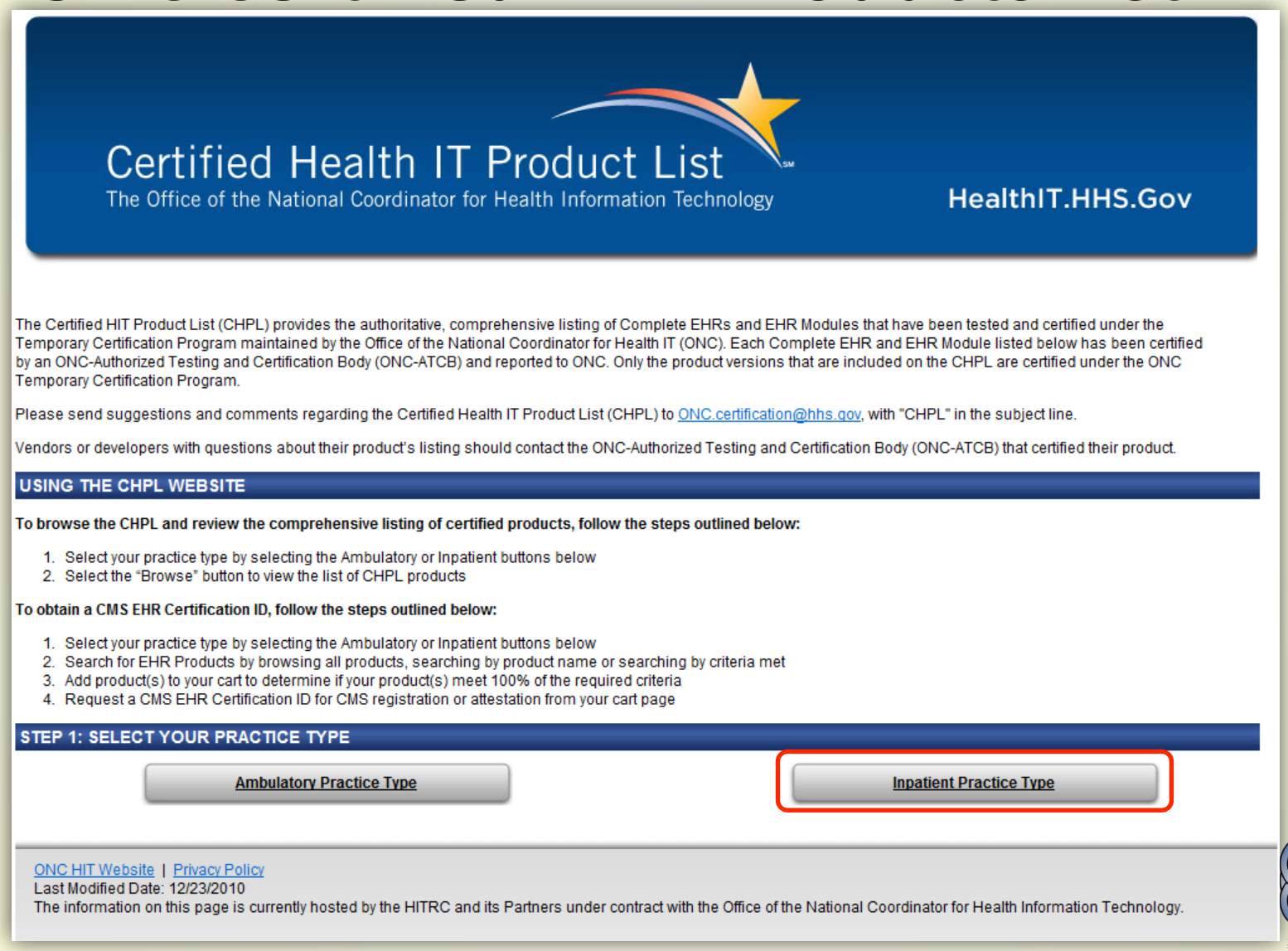
ONC Certified EHR Products List



Certified Health IT Product List

The Office of the National Coordinator for Health Information Technology

HealthIT.HHS.Gov

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

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

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

USING THE CHPL WEBSITE

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

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

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

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

STEP 1: SELECT YOUR PRACTICE TYPE

Ambulatory Practice Type | Inpatient Practice Type

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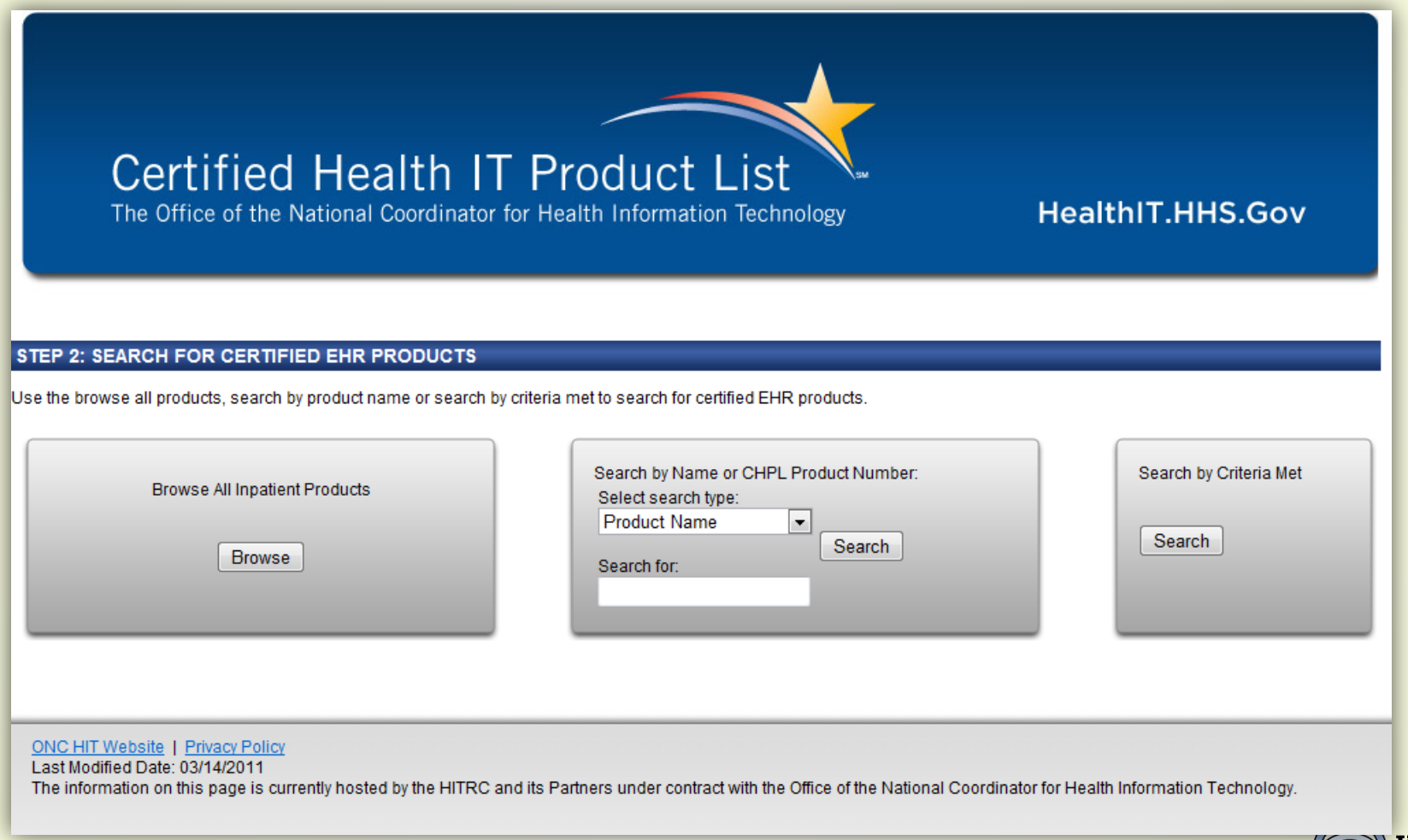
Choice to Search or Browse



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Using Browse…

Your Search Results: Showing 226-250 of 426 Products Found

STEP 3: ADD PRODUCTS TO YOUR CART

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

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

Matching Product ☐ See Complete Products Only

Certifying ATCB	Vendor	Product	Product Version#	Product Classification	Additional Software Required	
Drummond Group Inc.	MEDITECH (Medical Information Technology, Inc.)	MEDITECH MAGIC Public Health: Immunization Reporting	5.6.4	Modular EHR		Add to Cart
Drummond Group Inc.	MEDITECH (Medical Information Technology, Inc.)	MEDITECH MAGIC Public Health: Lab Reporting Interface	5.6.4	Modular EHR		Add to Cart
Drummond Group Inc.	MEDITECH (Medical Information Technology, Inc.)	MEDITECH MAGIC Public Health: Syndromic Surveillance Interface	5.6.4	Modular EHR		Add to Cart
CCHIT	Siemens Medical Solutions USA Inc	MedSeries4 EHR	2010	Complete EHR	Soarian Quality Reporting Service (SQRS);MedSeries4 Clinicals, V 31.1;OPENLink, V23.8;Pharmacy/Med Administration Check (MAK), V24.2 sp2	Add to Cart
CCHIT	Siemens Medical Solutions USA Inc	MedSeries4 EHR B2	2010	Modular EHR	MedSeries4 Clinicals, V31.1;Pharmacy/Med Administration Check (MAK), V24.2 sp2;OPENLink, V23.8	Add to Cart
CCHIT	Siemens Medical Solutions USA Inc	MedSeries4 EHR B2	2010	Modular EHR	MedSeries4 Clinicals, V31.1;OPENLink, V23.8;Pharmacy/Med Administration Check (MAK), V24.2 sp2	Add to Cart
ICSA Labs	Design Clinicals, Inc.	MedsTracker	5	Modular EHR	First Databank OrderView and NDDF, ExitCare	Add to Cart
InfoGard	Meta Pharmacy Systems, Inc. dba Meta Healthcare IT Solutions	MetaCare Enterprise EHR	6.0.0	Complete EHR	N/A	Add to Cart
InfoGard	M2 Information Systems, Inc.	MicrobloggingMD	2.0	Complete EHR	Cisco VPN 2.5.0217 used for §170.302.v to encrypt during transmission.	Add to Cart
Drummond Group Inc.	Microsoft Corporation	Microsoft Amalga UIS 2009	Release 2 Service Pack 1	Modular EHR		Add to Cart
Drummond Group Inc.	Microsoft Corporation	Microsoft Amalga UIS 2009	Release 2 Service Pack 3	Modular EHR	Email software	Add to Cart

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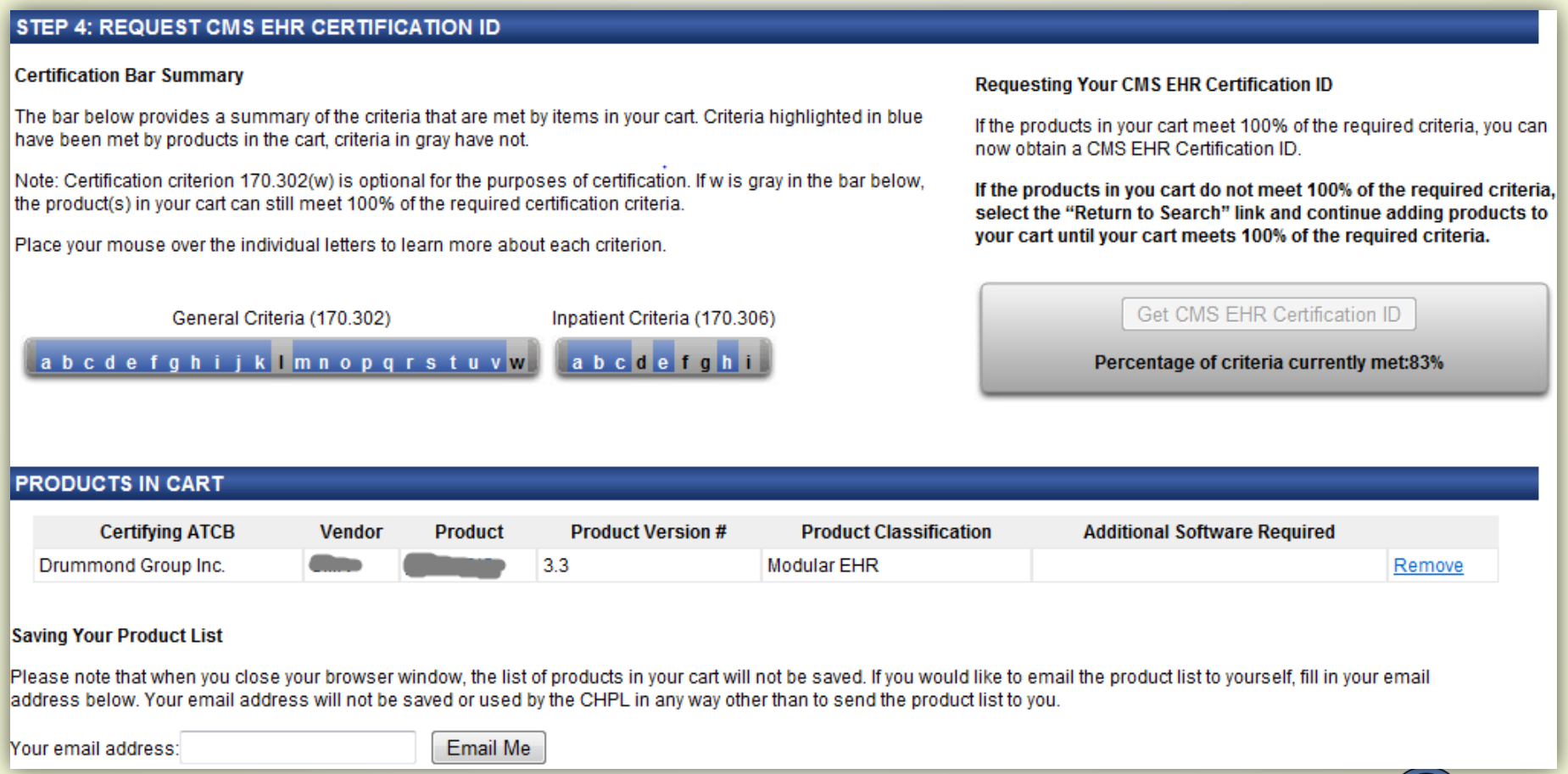
The Shopping Cart…



STEP 4: REQUEST CMS EHR CERTIFICATION ID

Certification Bar Summary

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

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

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

General Criteria (170.302)

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

Inpatient Criteria (170.306)

a b c d e f g h i

Requesting Your CMS EHR Certification ID

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

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

Get CMS EHR Certification ID

Percentage of criteria currently met:83%

PRODUCTS IN CART

Certifying ATCB	Vendor	Product	Product Version #	Product Classification	Additional Software Required	
Drummond Group Inc.	[redacted]	[redacted]	3.3	Modular EHR		Remove

Saving Your Product List

Please note that when you close your browser window, the list of products in your cart will not be saved. If you would like to email the product list to yourself, fill in your email address below. Your email address will not be saved or used by the CHPL in any way other than to send the product list to you.

Your email address: Email Me

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Certified Product Details

CERTIFICATION CRITERIA DETAIL VIEW

3.3

Certifying ATCB: Drummond Group Inc. | CHPL Product Number: 01192011-8607-1
Classification: Modular EHR | Practice Setting:Inpatient
Additional Software Required:

General Criteria (170.302)

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

Inpatient Criteria (170.306)

- ✓ (a) Computerized provider order entry
- ✓ (b) Record demographics
- ✓ (c) Clinical decision support
- ☐ (d) Electronic copy of health information
- ✓ (e) Electronic copy of discharge instructions
- ☐ (f) Exchange clinical information and patient summary record
- ☐ (g) Reportable lab results
- ✓ (h) Advance directives
- ☐ (i) Calculate and submit clinical quality measures

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Criteria Descriptions

Criteria Descriptions -- The following are the full descriptions to each of the certification criteria.

Section	Description
§170.302 (a)	Drug-drug, drug-allergy interaction checks. (1) Notifications. Automatically and electronically generate and indicate in real-time, notifications at the point of care for drug-drug and drug-allergy contraindications based on medication list, medication allergy list, and computerized provider order entry (CPOE). (2) Adjustments. Provide certain users with the ability to adjust notifications provided for drug-drug and drug-allergy interaction checks.
§170.302 (b)	Drug formulary checks. Enable a user to electronically check if drugs are in a formulary or preferred drug list.
§170.302 (c)	Maintain up-to-date problem list. Enable a user to electronically record, modify, and retrieve a patient's problem list for longitudinal care in accordance with: (1) The standard specified in §170.207(a)(1); or (2) At a minimum, the version of the standard specified in §170.207(a)(2).
§170.302 (d)	Maintain active medication list. Enable a user to electronically record, modify, and retrieve a patient's active medication list as well as medication history for longitudinal care.
§170.302 (e)	Maintain active medication allergy list. Enable a user to electronically record, modify, and retrieve a patient's active medication allergy list as well as medication allergy history for longitudinal care.
§170.302 (f)(1)	Record and Chart Vital signs. Enable a user to electronically record, modify, and retrieve a patient's vital signs including, at a minimum, the height, weight, and blood pressure.
§170.302 (f)(2)	Calculate Body mass index. Automatically calculate and display body mass index (BMI) based on a patient's height and weight.
§170.302 (f)(3)	Plot and display growth charts. Plot and electronically display, upon request, growth charts for patients 2-20 years old.
§170.302 (g)	Smoking status. Enable a user to electronically record, modify, and retrieve the smoking status of a patient. Smoking status types must include: current every day smoker; current some day smoker; former smoker; never smoker; smoker, current status unknown; unknown if ever smoked.
§170.302 (h)	Incorporate laboratory test results. 1) Receive results. Electronically receive clinical laboratory test results in a structured format and display such results in human readable format. 2) Display test report information. Electronically display all the information for a test report specified at 42 CFR 493.1291(c)(1) through (7). 3) Incorporate results. Electronically attribute, associate, or link a laboratory test result to a laboratory order or patient record.
§170.302 (i)	Generate patient lists. Enable a user to electronically select, sort, retrieve, and generate lists of patients according to, at a minimum, the data elements included in: (1) Problem list; (2) Medication list; (3) Demographics; and (4) Laboratory test results.
§170.302 (j)	Medication reconciliation. Enable a user to electronically compare two or more medication lists.
§170.302 (k)	Submission to immunization registries. Electronically record, modify, retrieve, and submit immunization information in accordance with: (1) the standard (and applicable implementation specifications) specified in §170.205(e)(1) or §170.205(e)(2); and (2) At a minimum, the version of the standard specified in §170.207(e).
§170.302 (l)	Public health surveillance. Electronically record, modify, retrieve, and submit syndrome-based public health surveillance information in accordance with the standard (and applicable implementation specifications) specified in §170.205(d)(1) or §170.205(d)(2).
§170.302 (m)	Patient specific education resources. Enable a user to electronically identify and provide patient-specific education resources according to, at a minimum, the data elements included in the patient's: problem list; medication list; and laboratory test results as well as provide such resources to the patient.
§170.302 (n)	Automated measure calculation. For each meaningful use objective with a percentage-based measure, electronically record the numerator and denominator and generate a report including the numerator, denominator, and resulting percentage associated with each applicable meaningful use measure.
§170.302 (o)	Access control. Assign a unique name and/or number for identifying and tracking user identity and establish controls that permit only authorized users to access electronic health information.
§170.302 (p)	Emergency access. Permit authorized users (who are authorized for emergency situations) to access electronic health information during an emergency.

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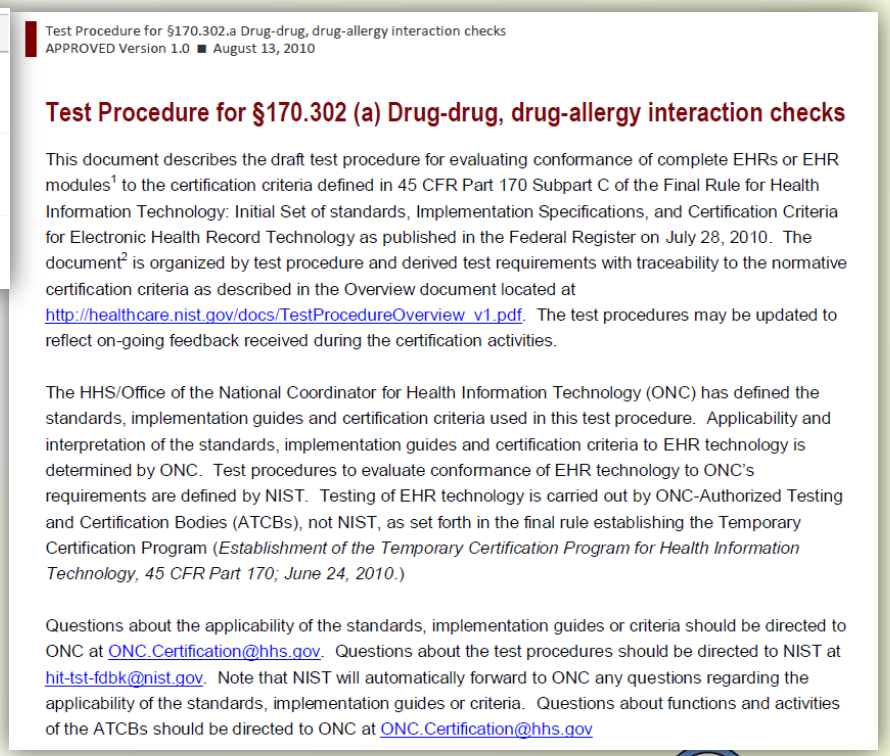
Testing Criteria

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

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



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

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

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

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

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

- Good resource to check if you wish to know what really has been tested
- Techies only need to look at this

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Outline

- Background to the Final Rule
- Financial Incentives for Hospitals
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- Quality Measures
- Knowing if Your EHR is Certified
- **Registering and Attesting**
- Physician Engagement
- Closure

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Incentive Program Registration & Attestation System

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

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Registration : Eligible Hospitals

- To register must enter
  - CMS Identity and Access Management (I&A) User ID and Password
  - TIN
  - CMS Certification Number (CCN)
  - NPI
- Authorized user can register for hospital
  - Complete additional login screens
  - Must have CMS Identify and Access Management (I&A) User ID and password
- CMS Certification Number and NPI must be associated with hospital's TIN
  - Discrepancies must be resolved in NPPES

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Registration: Eligible Hospitals, cont.

- Select Program (Medicare, Medicaid, both)
  - If you are eligible for both Medicare and Medicaid select both even if unsure if applying for both programs
  - Medicaid registration will be in pending status until state's program is launched
- Select Medicaid State
- Select hospital type
- Certified EHR Number (not required at point of registration)
  - Required for attestation
  - http://healthit.hhs.gov/CHPL to get certified EHR number
- Receive "Registration ID" upon successful registration
  - Print out the page for your records

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After Registration and Before Attestation

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

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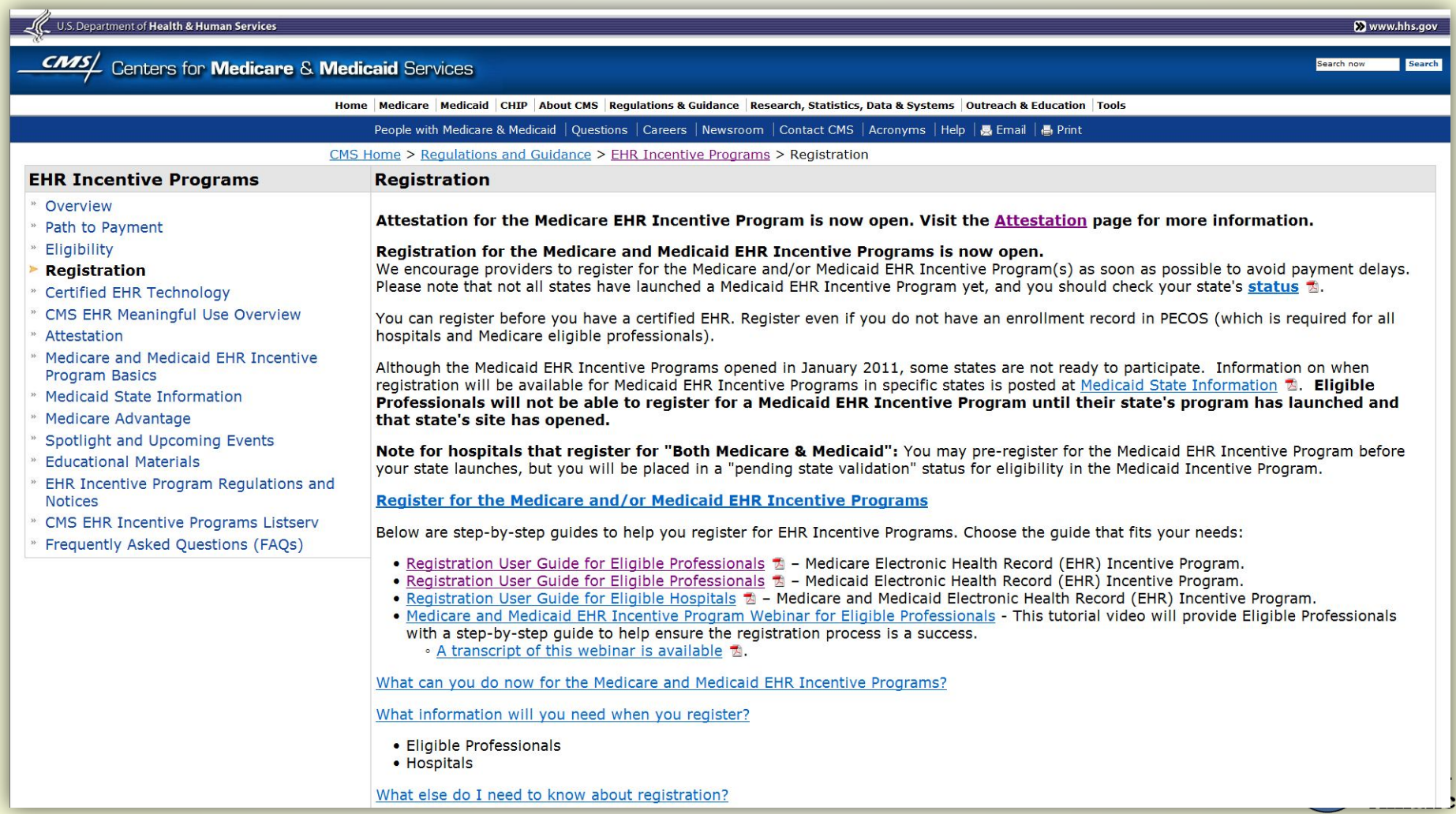
Registration Instructions

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



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EHR Incentive Programs

- Overview
- Path to Payment
- Eligibility
- **Registration**
- Certified EHR Technology
- CMS EHR Meaningful Use Overview
- Attestation
- Medicare and Medicaid EHR Incentive Program Basics
- Medicaid State Information
- Medicare Advantage
- Spotlight and Upcoming Events
- Educational Materials
- EHR Incentive Program Regulations and Notices
- CMS EHR Incentive Programs Listserv
- Frequently Asked Questions (FAQs)

Registration

Attestation for the Medicare EHR Incentive Program is now open. Visit the Attestation page for more information.

Registration for the Medicare and Medicaid EHR Incentive Programs is now open.
We encourage providers to register for the Medicare and/or Medicaid EHR Incentive Program(s) as soon as possible to avoid payment delays. Please note that not all states have launched a Medicaid EHR Incentive Program yet, and you should check your state's status.

You can register before you have a certified EHR. Register even if you do not have an enrollment record in PECOS (which is required for all hospitals and Medicare eligible professionals).

Although the Medicaid EHR Incentive Programs opened in January 2011, some states are not ready to participate. Information on when registration will be available for Medicaid EHR Incentive Programs in specific states is posted at Medicaid State Information. **Eligible Professionals will not be able to register for a Medicaid EHR Incentive Program until their state's program has launched and that state's site has opened.**

Note for hospitals that register for "Both Medicare & Medicaid": You may pre-register for the Medicaid EHR Incentive Program before your state launches, but you will be placed in a "pending state validation" status for eligibility in the Medicaid Incentive Program.

Register for the Medicare and/or Medicaid EHR Incentive Programs

Below are step-by-step guides to help you register for EHR Incentive Programs. Choose the guide that fits your needs:

- Registration User Guide for Eligible Professionals – Medicare Electronic Health Record (EHR) Incentive Program.
- Registration User Guide for Eligible Professionals – Medicaid Electronic Health Record (EHR) Incentive Program.
- Registration User Guide for Eligible Hospitals – Medicare and Medicaid Electronic Health Record (EHR) Incentive Program.
- Medicare and Medicaid EHR Incentive Program Webinar for Eligible Professionals - This tutorial video will provide Eligible Professionals with a step-by-step guide to help ensure the registration process is a success.
  - A transcript of this webinar is available.

What can you do now for the Medicare and Medicaid EHR Incentive Programs?

What information will you need when you register?

- Eligible Professionals
- Hospitals

What else do I need to know about registration?

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Registration Guide for EHs

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

REGISTRATION
USER GUIDE
For Eligible Hospitals

Medicare and Medicaid
Electronic Health Record
(EHR) Incentive Program

EHR
INCENTIVE PROGRAM

JULY 2011
(07.29.11 ver3)

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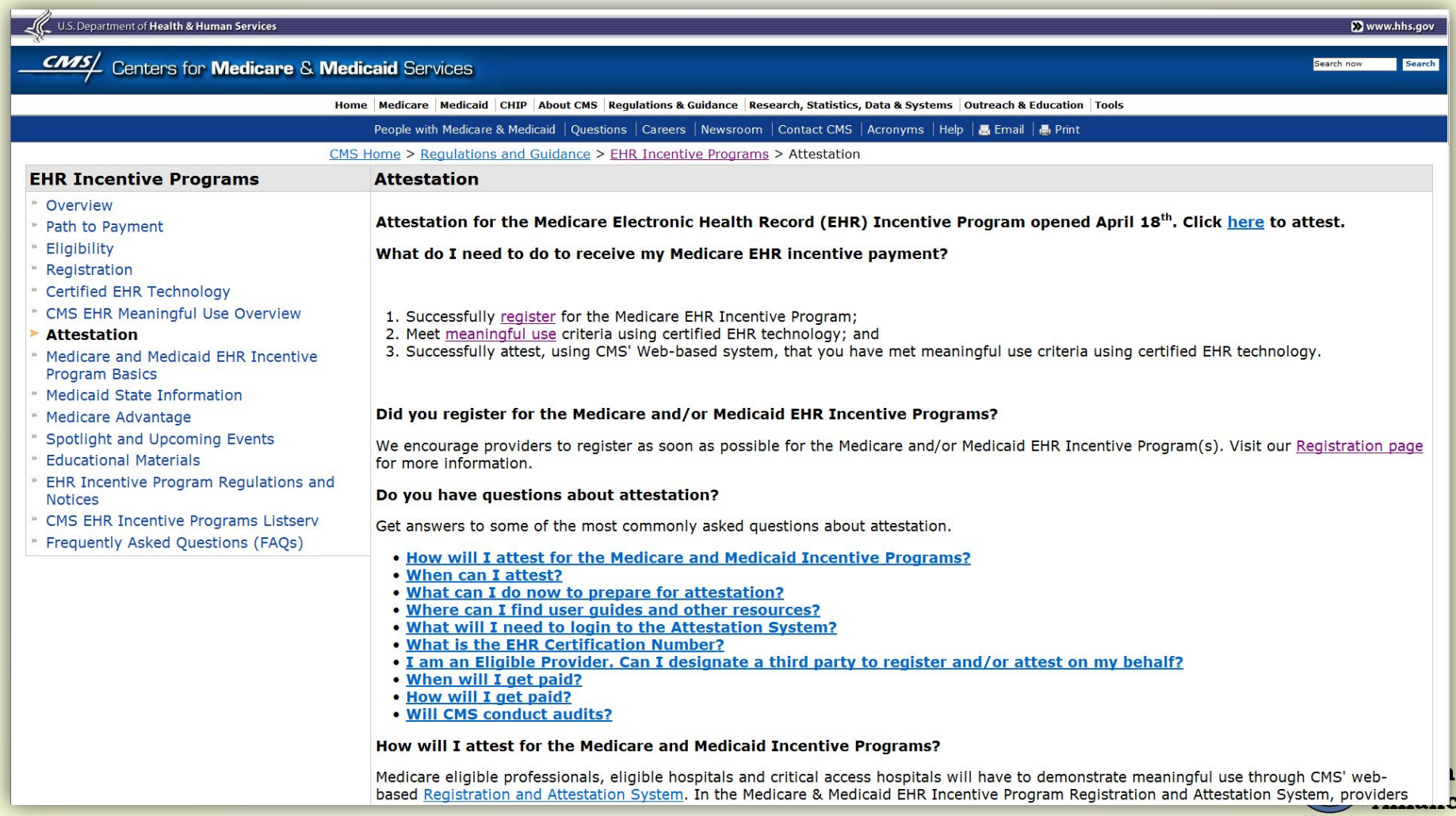
Disclaimer

The Centers for Medicare & Medicaid Services (CMS) is providing this material as an informational reference for physicians and non-physician practitioners-providers. Although every reasonable effort has been made to assure the accuracy of the information within these pages at the time of posting, the Medicare program is constantly changing, and it is the responsibility of each physician, non-physician practitioner, supplier or provider to remain abreast of the Medicare program requirements.

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

Attestation Instructions

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



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EHR Incentive Programs

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- Medicare Advantage
- Spotlight and Upcoming Events
- Educational Materials
- EHR Incentive Program Regulations and Notices
- CMS EHR Incentive Programs Listserv
- Frequently Asked Questions (FAQs)

Attestation

Attestation for the Medicare Electronic Health Record (EHR) Incentive Program opened April 18th. Click here to attest.

What do I need to do to receive my Medicare EHR incentive payment?

1. Successfully register for the Medicare EHR Incentive Program;
2. Meet meaningful use criteria using certified EHR technology; and
3. Successfully attest, using CMS' Web-based system, that you have met meaningful use criteria using certified EHR technology.

Did you register for the Medicare and/or Medicaid EHR Incentive Programs?

We encourage providers to register as soon as possible for the Medicare and/or Medicaid EHR Incentive Program(s). Visit our Registration page for more information.

Do you have questions about attestation?

Get answers to some of the most commonly asked questions about attestation.

- **How will I attest for the Medicare and Medicaid Incentive Programs?**
- **When can I attest?**
- **What can I do now to prepare for attestation?**
- **Where can I find user guides and other resources?**
- **What will I need to login to the Attestation System?**
- **What is the EHR Certification Number?**
- **I am an Eligible Provider. Can I designate a third party to register and/or attest on my behalf?**
- **When will I get paid?**
- **How will I get paid?**
- **Will CMS conduct audits?**

How will I attest for the Medicare and Medicaid Incentive Programs?

Medicare eligible professionals, eligible hospitals and critical access hospitals will have to demonstrate meaningful use through CMS' web-based Registration and Attestation System. In the Medicare & Medicaid EHR Incentive Program Registration and Attestation System, providers

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Attestation Worksheet

Eligible Hospital and Critical Access Hospital (CAH) Attestation Worksheet for the Medicare Electronic Health Record (EHR) Incentive Program

The Eligible Hospital and CAH Attestation Worksheet allows eligible hospitals and CAHs to log their meaningful use measures on this page to use as a reference when attesting for the Medicare EHR Incentive Program in the CMS system.

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

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

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

Eligible hospitals and CAHs must report on the following:

1. All 14 of the core measures;
2. 5 out of 10 of the menu measures; at least 1 public health measure must be selected as part of the 5
3. All 15 of the clinical quality measures (CQMs)

Reporting Period: For an eligible hospital or critical access hospital, the reporting period must be at least 90 consecutive days within Federal Fiscal Year 2011 (October 1, 2010, through September 30, 2011).

Meaningful Use Core Measures - Eligible hospitals and CAHs must fill out all 14 core measures

#	Measure Information	Measure Values
1	**Objective:** Use computerized provider order entry (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. **Measure:** More than 30 percent of all unique patients with at least one medication in their medication list admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) have at least one medication order entered using CPOE	
	Numerator: Number of patients in the denominator that have at least one medication order entered during CPOE	
	Denominator: Number of unique patients with at least one medication in their medication list seen by the eligible hospital or CAH during the EHR reporting period	
2	**Objective:** Implement drug-drug and drug-allergy interaction checks **Measure:** The eligible hospital or CAH has enabled the functionality for drug-drug and drug-allergy interaction checks for the entire EHR reporting period **Note: This measure only requires a yes/no answer**	
	Numerator: N/A	☐ YES ☐ NO
	Denominator: N/A	
3	**Objective:** Maintain an up-to-date problem list of current and active diagnoses **Measure:** More than 80 percent of all unique patients admitted to the eligible hospital or CAH's inpatient or emergency department (POS 21 or 23) have at least one entry or an indication that no problems are known for the patient recorded as structured data	
	Numerator: Number of patients in the denominator who have at least one entry or indication that no problems are known for the patient recorded as structured data in their problem list	
	Denominator: Number of unique patients admitted to an eligible hospital or CAH's inpatient or emergency department (POS 21 or 23) during the EHR report period	
4	**Objective:** Maintain active medication list **Measure:** More than 80 percent of all unique patients admitted to the eligible hospital or CAH's inpatient or emergency department (POS 21 or 23) have at least one entry (or an indication that the patient is not currently prescribed any medication) recorded as structured data	
	Numerator: Number of patients in the denominator who have a medication (or an indication that the patient is not currently prescribed any medication) recorded as structured data	
	Denominator: Number of unique patients admitted to an eligible hospital or CAH's inpatient or emergency department (POS 21 or 23) during the EHR report period	

Registration and Attestation Instructions

- Registration and attestation instructions:
  - http://www.cms.gov/EHRIncentivePrograms/20_RegistrationandAttestation.asp
- Registration video:
  - http://www.youtube.com/watch?v=ExOQOaYwie4&feature=relmfu
- Attestation video:
  - http://www.youtube.com/watch?v=bXcNkNOCV6A&feature=relmfu

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Important Dates

- April 18, 2011
  - Attestation for the Medicare EHR Incentive Program began.
- May 2011
  - EHR Incentive Payments began.
- July 3, 2011
  - Last day for eligible hospitals to have begun their 90-day reporting period for fiscal year 2011 for the Medicare EHR Incentive Program.
- September 30, 2011
  - Reporting year ends for eligible hospitals.
- November 30, 2012
  - Last day for eligible hospitals to register and attest to receive an Incentive Payment for fiscal year (FY) 2011
- October 1, 2011
  - First day for eligible hospitals to begin their reporting period for fiscal year 2012 for the Medicare EHR Incentive Program.

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Register Now

- Hospitals
  - May register for the Medicare program and attest to meaningful use now
  - May not select the Medicaid program until state Medicaid program ready
  - Recommend registering early to be sure all information is available and correct
- State readiness:
  - http://www.cms.gov/apps/files/medicaid-HIT-sites/

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Outline

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- **Physician Engagement**
- Closure

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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 do not see the benefit to quality and they believe it will go down in the short run

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Challenges Physicians Might Encounter

- Lots of clicks
- Frequent logins
- 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
- 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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- **Denial** — "I feel fine."; "This can't be happening, not to me."
  Denial is usually only a temporary defense for the individual. This feeling is generally replaced with heightened awareness of possessions and individuals that will be left behind after death.
- **Anger** — "Why me? It's not fair!"; "How can this happen to me?"; '"Who is to blame?"
  Once in the second stage, the individual recognizes that denial cannot continue. Because of anger, the person is very difficult to care for due to misplaced feelings of rage and envy.
- **Bargaining** — "I'll do anything for a few more years."; "I will give my life savings if..."
  The third stage involves the hope that the individual can somehow postpone or delay death. Usually, the negotiation for an extended life is made with a higher power in exchange for a reformed lifestyle. Psychologically, the individual is saying, "I understand I will die, but if I could just do something to buy more time..."
- **Depression** — "I'm so sad, why bother with anything?"; "I'm going to die soon so what's the point... What's the point?"; "I miss my loved one, why go on?"
  During the fourth stage, the dying person begins to understand the certainty of death. Because of this, the individual may become silent, refuse visitors and spend much of the time crying and grieving. This process allows the dying person to disconnect from things of love and affection. It is not recommended to attempt to cheer up an individual who is in this stage. It is an important time for grieving that must be processed.
- **Acceptance** — "It's going to be okay."; "I can't fight it, I may as well prepare for it."
  In this last stage, individuals begin to come to terms with their mortality, or that of a loved one, or other tragic event.

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."

Small Groups

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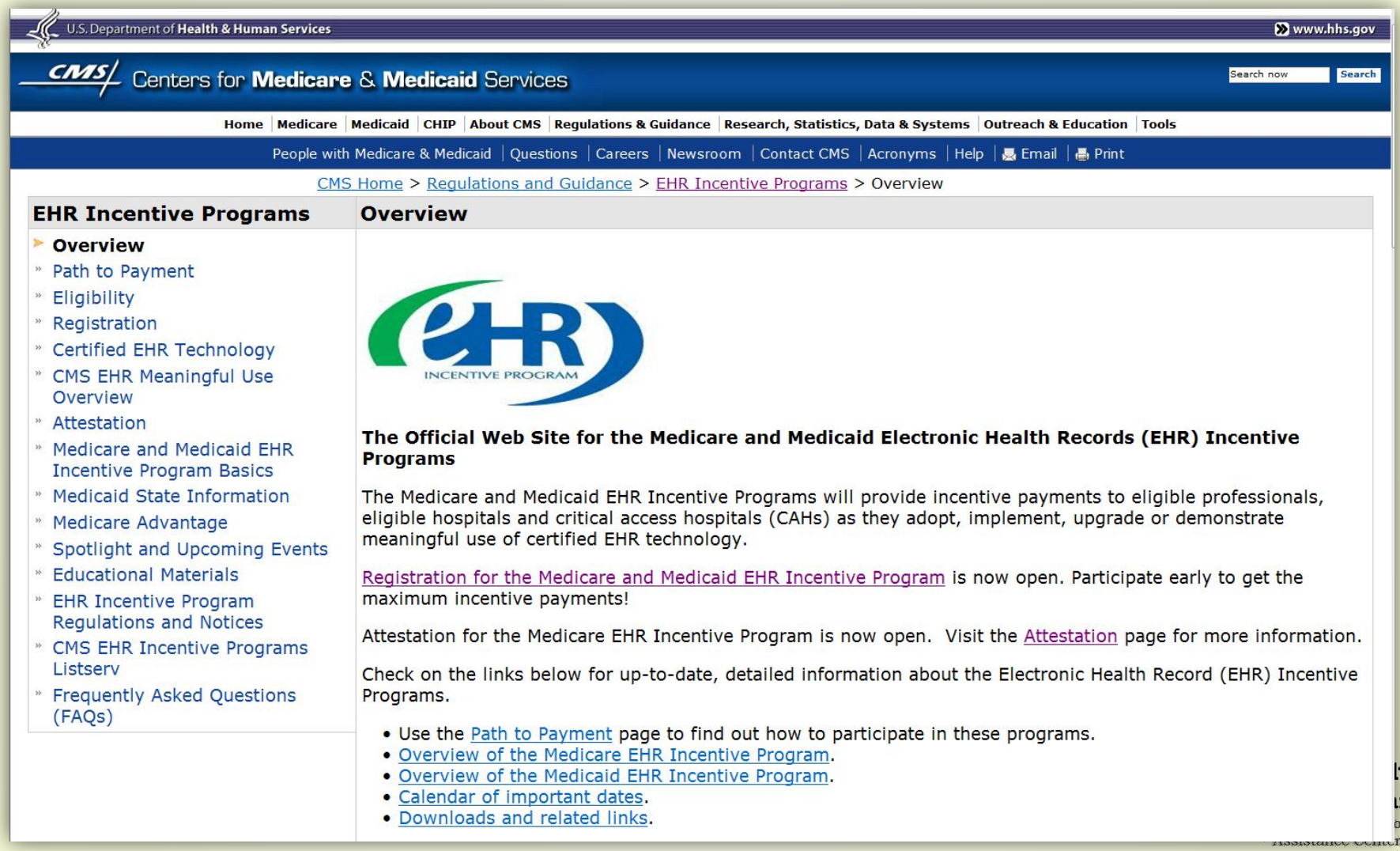
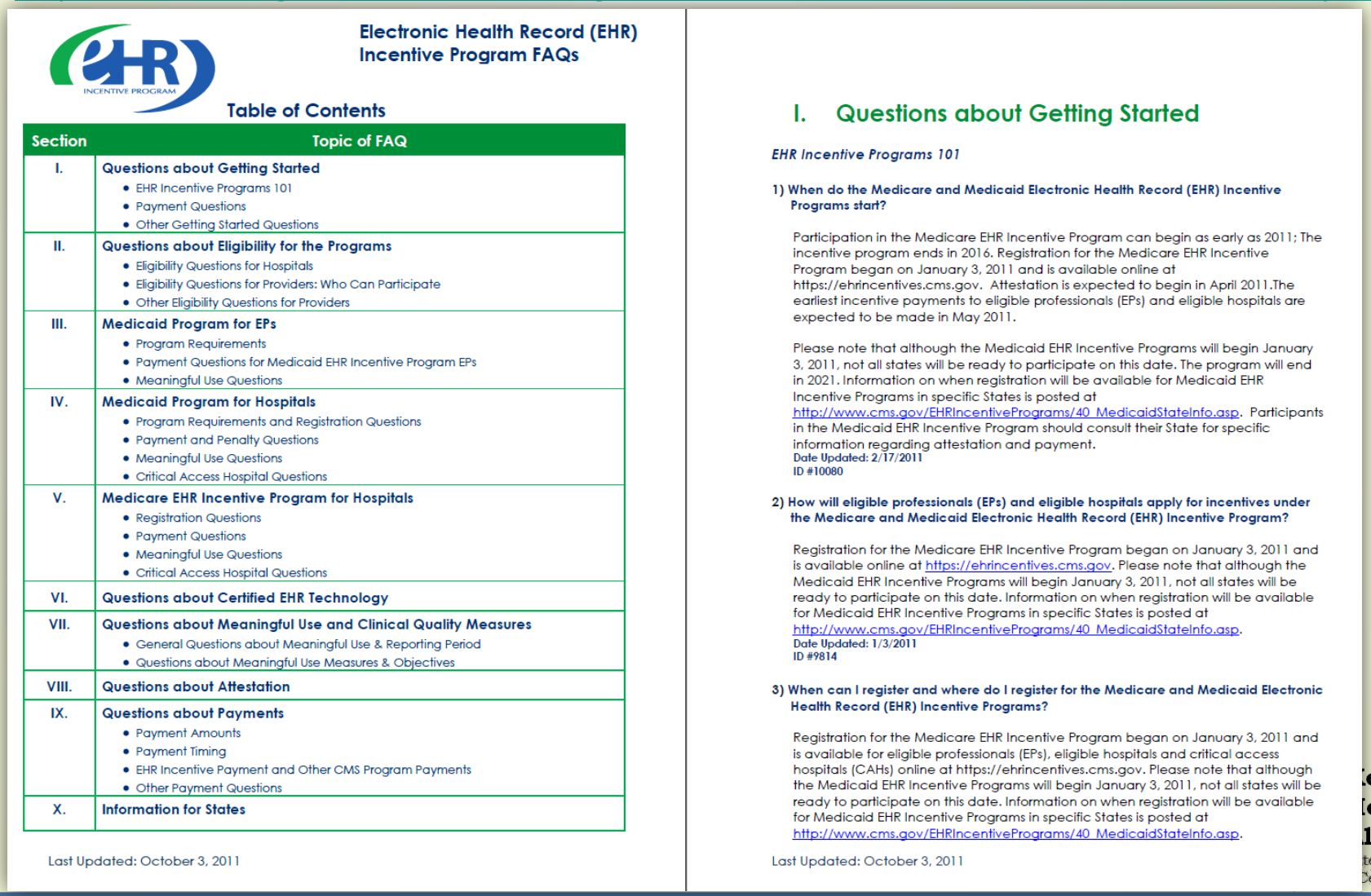
CMS Meaningful Use Website

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

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III.	**Medicaid Program for EPs** • Program Requirements • Payment Questions for Medicaid EHR Incentive Program EPs • Meaningful Use Questions
IV.	**Medicaid Program for Hospitals** • Program Requirements and Registration Questions • Payment and Penalty Questions • Meaningful Use Questions • Critical Access Hospital Questions
V.	**Medicare EHR Incentive Program for Hospitals** • Registration Questions • Payment Questions • Meaningful Use Questions • Critical Access Hospital Questions
VI.	**Questions about Certified EHR Technology**
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X.	**Information for States**

Last Updated: October 3, 2011

I. Questions about Getting Started

EHR Incentive Programs 101

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

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

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

Date Updated: 2/17/2011
ID #10080

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

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

Date Updated: 1/3/2011
ID #9814

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

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

Last Updated: October 3, 2011

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Resources Mentioned in the Talk:

- CMS Websites
  - "Meaningful Use" on the CMS web site:
    - https://www.cms.gov/EHRIncentivePrograms/
  - Registration instructions for eligible hospitals:
    - http://www.cms.gov/EHRIncentivePrograms/20_RegistrationandAttestation.asp
  - Meaningful Use Specification Sheet (A downloadable PDF index that links FAQ's online)
    - https://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 Worksheet
    - https://www.cms.gov/EHRIncentivePrograms/Downloads/Hospital_Attestation_Worksheet.pdf
- ONC-ATCB Certified EHRs and what modules they are certified for:
  - http://healthit.hhs.gov/chpl
- Testing criteria for each of the EHR modules:
  - http://healthcare.nist.gov/use_testing/effective_requirements.html
- Quality Measure Specifications on the CMS web site:
  - http://www.cms.gov/QualityMeasures/03_ElectronicSpecifications.asp
- HITSP Technical Notes:
  - http://www.hitsp.org/Handlers/HitspFileServer.aspx?FileGuid=088df74b-3bac-49ef-9de4-b99e24879035
- Videos
  - Registration video:
    - http://www.youtube.com/watch?v=ExOQOaYwie4&feature=relmfu
  - Attestation video:
    - http://www.youtube.com/watch?v=bXcNkNOCV6A&feature=relmfu

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Other Resources:

- Regional Extension Assistance Center for Health Information Technology (REACH)
  - http://www.khaREACH.org
- Stratis Health HIT Toolkits for hospitals
  - http://www.stratishealth.org/expertise/healthit/hospitals/index.html
- "Meaningful Use" information on the Health and Human Services web site:
  - http://healthit.hhs.gov/meaningfuluse
- Office of the National Coordinator Health IT site:
  - http://HealthIT.gov
- MN-DHS Medicaid EHR Incentives Website:
  - http://www.dhs.state.mn.us/ehrincentives

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In Review

- The EHR Incentive program is intended to encourage the health care industry to adopt and meaningfully use health information Technology
- Incentives are available for hospitals who adopt certified EHR technology and meaningfully use it
- Meaningful use will require the submission of quality measures
- Criteria for meaningful use will become more demanding over time with demonstrated improvement of quality will likely be required to be considered for incentives or payment increases
- Efficient and accurate collection of patient information and quality measures as well as improvement in those measures will require close attention to workflow
- Use reports on a regular basis to track your progress to meaningful use your EHR and improved quality

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Thank you!

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Key Health Alliance—Stratis Health, Rural Health Resource Center, and The College of St. Scholastica.

REACH is a project federally funded through the Office of the National Coordinator, Department of Health and Human Services.