MAeHC
Massachusetts eHealth Collaborative

Making Meaningful Use Meaningful

Stage 1 – 2014
Agenda

What is Meaningful Use

Looking Back at EHR Implementations

How Do We Improve

Meaningful Use Road Map

Re-Thinking Meaningful Use for Success

Meaningful Use in Practice

References
It Stars with the American Recovery and Reinvestment Act

One Hundred Eleventh Congress
of the
United States of America

AT THE FIRST SESSION

Begun and held at the City of Washington on Tuesday,
the sixth day of January, two thousand and nine

An Act

Making supplemental appropriations for job preservation and creation, infrastructure investment, energy efficiency and science, assistance to the unemployed, and State and local fiscal stabilization, for the fiscal year ending September 30, 2009, and for other purposes.
Transforming Healthcare through the Three-Part Aim

Three-Part Aim:

⭐ Better Healthcare ⭐ Better Health ⭐ Reduced Costs

Paper Records
Pre 2009
A system plagued by inefficiencies

HITECH Act
2009
EHR Incentive Program and 62 Regional Extension Centers

EHRs & HIE
2014
Widespread adoption & meaningful use of EHRs
What is Meaningful Use?

The Recovery Act specifies the 3 components of Meaningful Use:

• Use of certified EHR in a **meaningful manner** (e.g., e-prescribing)

• Use of certified EHR technology for **electronic exchange** of health information to improve quality of health care

• Use of certified EHR technology to submit **clinical quality measures** (CQM) and other such measures selected by the Secretary

But… What we have learned is that Meaningful Use is simply a measure of EHR adoption and a by-product of a good EHR implementation

“Meaningful Use Happens”
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What Went Wrong?

Practices are taking paper processes and putting them in the computer
  ➢ Not working to redesign workflow to incorporate technology

Practices are not effectively training – new staff are trained by old staff
  ➢ Not completing the recommended hours or learning functionality

Using “out of the box” tools, alerts and CDS without customization
  ➢ Alerts & reminders not always clinically relevant – “provider fatigue”

Provider centric model instead of patient centric model
  ➢ Providers not using care team approach to maximize efficiency

Minimal documentation at the point of care
  ➢ EHR tools become ineffective and providers miss MU thresholds
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Ways to Improve

✓ Maximize training time to fully understand EHR functionality and capabilities – use vendor training tools and classes

✓ Customize or remove inappropriate CDS, alerts and reminders

✓ Maximize availability of hardware to access EHR throughout the office

✓ Utilize care teams based on credentials to maximize data entry and empower support staff to take action on alerts and reminders

✓ Embrace technology in the exam room and document at the point of care

✓ Leverage your patients and their families as resources by giving them tools and education for self management and care coordination
Practices Need to Take a Holistic View of Workflow Redesign

- Staff roles & responsibilities
- Credentials and capabilities

- Right place, right time
- Policies & Procedures

- Using technology effectively
- Privacy & Security

- People
- Process
- Technology
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Meaningful Use Stage 1 Focuses on Local Data Capture and Basic EHR Functionality

Stage 1
2011-14

Stage 2
2014-16

Stage 3
2016-17

Better clinical outcomes
Improved population health outcomes
Increased transparency and efficiency
Empowered individuals
More robust research data on health system
Meaningful Use has Five Health Related Goals

1. Improve quality, safety, efficiency and reduce health disparities
2. Engage patients and families in their health care
3. Improve care coordination
4. Improve population and public health
5. Ensure adequate privacy and security protections for personal health information
Meaningful Use is the Building Block for other Clinical Transformation Initiatives

- Improved population health
- Enhanced access and continuity
- Patient engaged, community resources
- Data utilized to improve delivery and outcomes
- Patient self management
- Registries to manage patient populations
- Team based care, case management
- Registries for disease management
- Evidenced based medicine
- Patient centered care coordination
- Privacy & security protections
- Structured data utilized
- Care coordination
- Patient informed
- Patient self management
- Privacy & security protections
- Basic EHR functionality, structured data
- Data utilized to improve delivery and outcomes
- Registries to manage patient populations
- Privacy & security protections
- Privacy & security protections
- Utilize technology
- Access to information

Stage 1 MU
Stage 2 MU
Million Hearts
PCMH / Stage 3 MU
Agenda

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2014 Stage 1 Meaningful Use Objectives

Core Set: Must Do All

- Use CPOE
- e-prescribing
- Drug-drug & drug allergy checks
- Medication list
- Allergy list
- Problem list
- Decision support (CDSS)
- Record demographics
- Smoking status
- Vital signs
- Clinical summaries to patient
- Protect health information
- Patient electronic access to view, download and transmit

Menu Set: Must Do 5 of 9

- Incorporate clinical labs
- Medication reconciliation
- Implement drug-formulary checks
- Generate patient list
- Send reminder
- Patient-specific education
- Clinical summaries to provider
- Submit electronic data to immunization registry*
- Submit electronic syndromic surveillance data*

*At least 1 public health objective must be selected. Exceptions for menu items do not count towards the total. You must use a different menu item if possible.
Stage 1 - Meaningful Use objectives and standards correlate with health related goals

Objectives relate to health related goals

**Objective**
13 Core Objectives

**Standard**
Providers must meet all standards unless an exception applies.

**Objective**
9 Menu Objectives

**Standard**
Providers may defer up to 5 items for Stage 1. One menu item selected must be related to public health reporting.
Look at Your Workflow First!

Patient & Family Engagement

Pre-Visit → Registration → Patient Intake → Provider Visit → Check-Out → Post Visit

Privacy & Security

Continuous Quality improvement
Meaningful Use Objectives Follow Patient Flow
Care Team Extends Outside the Practice Walls

Patient & Families

- PCP
- Home Health / LTC
- eHealth Portals
- Mobile Technology
- Diagnostic Testing
- Specialty Care
- Acute Care
How is meaningful use different for specialists?

- **It is not!** The objectives may appear to have a Primary Care focus, but are required for all providers unless they qualify for an exclusion to an objective.

- Many exclusions may apply to the practice, but clear policies must be documented, i.e., Vital signs not taken.

- Must have a detailed understanding of how your EHR vendor is calculating the denominator, i.e., Office Visits, Office Procedures, SOAP note or OP note? For example, Clinical Summaries are only required for E&M services, not procedural services.

- Often you can manipulate the reports based on visit type or document type to exclude certain visits or procedures.

- Key data elements can be collected and entered by specific staff so leveraging your skill sets and time is critical as your practice develops its workflow.
Keys to Future Success

✓ Care team based approach to maximize data entry into EHR
  ➢ Preparation for LOINC, SNOMED and ICD10 terminology
  ➢ Preparation for increased objective thresholds

✓ Maximize point of care documentation to leverage EHR functionality (alerts, reminders, CDS) and provide real-time medical summary

✓ Establish external connectivity through results interface and Health Information Exchange (HIE)
  ➢ Receive structured data through HL7 interface and CCD exchange

✓ Establish online patient access and communication (Patient Portal) for access to clinical information and secure messaging
  ➢ Opportunity to have patient input of social and family HX
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References
Patient receives notification as a reminder of visit or clinical need
Office staff generates report and reminder letters for patients with upcoming appointments and procedures

- Send patient reminder letters for visit or procedure
- Send reminder letter to target population by diagnosis

Examples only
Pre-Visit tasks meet two Menu objectives (I)

Improve quality, safety, efficiency and reduce health disparities

Objective
Generate lists of patients by specific conditions to use for quality improvement, reduction of disparities, research or outreach

Standard
Generate at least one report listing patients of the EP with a specific condition

Requires only Yes / No Attestation
Exclusion Criteria

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<tr>
<td>Requires Only</td>
<td>Exclusion Criteria</td>
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<tr>
<td>Yes / No Attestation</td>
<td>None</td>
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</table>

Pre-Visit tasks meet two Menu objectives (II)

Improve quality, safety, efficiency and reduce health disparities

Objective: Send reminders to patients per patient preference for preventive/ follow up care

Standard: More than 20% of all unique patients 65 years or older or 5 years old or younger were sent an appropriate reminder during the EHR reporting period.

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<tbody>
<tr>
<td>The number of patients in the denominator who were sent the appropriate reminder.</td>
<td>Number of unique patients 65 years old or older or 5 years older or younger.</td>
<td>Patients whose Records are Maintained in the EHR.</td>
<td>If an EP has no patients 65 years old or older or 5 years old or younger with records maintained using certified EHR technology</td>
</tr>
</tbody>
</table>

Patient arrives at clinical practice for services

Patient & Family Engagement

Pre-Visit → Registration → Patient Intake → Provider Visit → Check-Out → Post Visit

Privacy & Security
Front desk staff verify and update Patient’s demographics and billing information

Registration

- Date of birth
- Gender
- Preferred language
- Ethnicity
- Race
- Contact Information & Preferences

Mailing, Voicemail, Patient Portal access
Registration function meets one Core objective

Improve quality, safety, efficiency and reduce health disparities

<table>
<thead>
<tr>
<th>Objective</th>
<th>Standard</th>
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</thead>
<tbody>
<tr>
<td>Record demographics: preferred language, gender, race, ethnicity, date of birth</td>
<td>More than 50% of all unique patients seen by the EP have demographics recorded as structured data</td>
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</table>

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</thead>
<tbody>
<tr>
<td>The number of patients in the denominator who have all the elements of demographics (or a specific exclusion if the patient declined to provide one or more elements) recorded as structured data.</td>
<td>Number of unique patients seen by the EP during the EHR reporting period.</td>
<td>All Unique Patients.</td>
<td>None</td>
</tr>
</tbody>
</table>

Registration function meets one Core objective

Objective: Record demographics: preferred language, gender, race, ethnicity, date of birth

Standard: More than 50% of all unique patients seen by the EP have demographics recorded as structured data

**Race Categories:**
- American Indian or Alaska Native
- Asian
- Black or African American
- Native Hawaiian or Other Pacific Islander
- White

**Ethnicity Categories:**
- Hispanic or Latino
- Not Hispanic or Latino

*Patients can refuse to report
Patient moves to the clinical area to prepare for provider visit or procedure
Medical Assistants/Nurses update Patient’s vital signs in structured data fields and review or update medical summary information

- Record blood pressure
- Record height, weight, calculate BMI
- Plot and display growth chart (age appropriate)
- Record or review smoking status
- Verify, update allergy list, or NKDA
- Verify, update current medications, or annotate “none”

If Vital Signs are clinically relevant or appropriate
Patient Intake meets four Core objectives

Improve quality, safety, efficiency and reduce health disparities

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<th>Population</th>
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</thead>
<tbody>
<tr>
<td>Maintain active medication list</td>
<td>Number of unique patients seen by the EP during the EHR reporting period.</td>
<td>All Unique Patients.</td>
<td>None</td>
</tr>
</tbody>
</table>

The 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.

Patient Intake meets four Core objectives

Improve quality, safety, efficiency and reduce health disparities

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<tr>
<th>Objective</th>
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<th>Denominator</th>
<th>Population</th>
<th>Exclusion Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maintain active medication allergy list</td>
<td>The number of unique patients in the denominator who have at least one entry (or an indication that the patient has no known medication allergies - NKDA) recorded as structured data in their medication allergy list.</td>
<td>Number of unique patients seen by the EP during the EHR reporting period.</td>
<td>All Unique Patients.</td>
<td>None</td>
</tr>
</tbody>
</table>

### Patient Intake meets four Core objectives

**Improve quality, safety, efficiency and reduce health disparities**

- **Objective**: Record and chart changes in vital signs: Height, Weight, Blood pressure

- **Standard**: More than 50% of all unique patients seen by the EP during the EHR reporting period have blood pressure (for patients age 3 and over only) and height and weight (for all ages) recorded as structured data

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</thead>
<tbody>
<tr>
<td>The number of patients in the denominator who have at least one entry of their height, weight and blood pressure are recorded as structure data.</td>
<td>Number of unique patients age 3 or over seen by the EP during the EHR reporting period.</td>
<td>Patients whose records are maintained in the EHR.</td>
<td>EP sees no patients 3 years or older (not have to record blood pressure), if all three vital signs are not relevant to scope of practice, if height and weight not relevant to scope of practice (still record blood pressure), or if blood pressure is not relevant to scope of practice (still record height and weight).</td>
</tr>
</tbody>
</table>

Patient Intake meets four Core objectives

Improve quality, safety, efficiency and reduce health disparities

<table>
<thead>
<tr>
<th>Objective</th>
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<tbody>
<tr>
<td>Record smoking status for patients 13 years old or older</td>
<td>More than 50% of all unique patients 13 years old or older seen by the EP have smoking status recorded as structured data</td>
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<tbody>
<tr>
<td>The number of patients in the denominator with smoking status recorded as structured data.</td>
<td>Number of unique patients age 13 or older seen by the EP during the EHR reporting period.</td>
<td>Patients whose Records are Maintained in the EHR.</td>
<td>EPs who see no patients 13 years or older</td>
</tr>
</tbody>
</table>

Patient Intake meets four Core objectives

Improve quality, safety, efficiency and reduce health disparities

Objective
Record smoking status for patients 13 years old or older

Standard
More than 50% of all unique patients 13 years old or older seen by the EP have smoking status recorded as structured data

**Smoking status types must include:**
- current every day smoker
- current some day smoker
- former smoker
- never smoker
- lighter smoker
- current status unknown
- unknown if ever smoked
- heavy tobacco smoker
- light tobacco smoker
Provider and Patient interact at point of care
Provider conducts patient consult or procedure

- Provider documents consult or procedure
- Provider determines problem or diagnosis
- Updates patient problem list, or documents “none”

The use of templates can increase speed, efficiency and accuracy but is not required for MU. The use of dictation, voice recognition or free text is possible, but you may lose the ability to use Evaluation and Management (E&M) coders.
**Provider assessment meets one Core objective**

Improve quality, safety, efficiency and reduce health disparities

**Objective**
Maintain an up-to-date problem list of current and active diagnoses

**Standard**
More than 80% of all unique patients seen by the EP have at least one entry, or an indication that no problems are known for the patient, recorded as structured data

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<tbody>
<tr>
<td>The number of patients in the denominator who have at least one entry or an indication that no problems are known for the patient recorded as structured data in their problem list.</td>
<td>Number of unique patients seen by the EP during the EHR reporting period.</td>
<td>All Unique Patients.</td>
<td>None</td>
</tr>
</tbody>
</table>

Provider determines Patient’s care plan

- Reviews alerts, reminders, quality indicators
- Uses diagnosis based order sets or clinical decision tools
- Use EHR to order and transmit lab request

A lab interface is not required for Stage 1 but facilitates the ability to comply with CQM, results management and patient engagement
Provider care plan meets one Core objective

Improve quality, safety, efficiency and reduce health disparities

**Objective**
Implement one clinical decision support rule relevant to specialty or high clinical priority along with the ability to track compliance with that rule

**Standard**
Implement one clinical decision support rule

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<tr>
<td>X</td>
<td>None</td>
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Provider care plan meets one Menu objective

Improve quality, safety, efficiency and reduce health disparities

<table>
<thead>
<tr>
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<tbody>
<tr>
<td>Incorporate clinical lab test results into certified EHR technology as structured data</td>
<td>More than 40% of all clinical lab tests results ordered by the EP during the EHR reporting period whose results are either in a positive/negative or numerical format are incorporated in certified EHR technology as structured data</td>
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<tbody>
<tr>
<td>The number of lab test results whose results are expressed in a positive or negative affirmation or as a number which are incorporated as structured data.</td>
<td>Number of lab tests ordered during the EHR reporting period by the EP whose results are expressed in a positive or negative affirmation or as a number.</td>
<td>Patients whose Records are Maintained in the EHR.</td>
<td>If an EP orders no lab tests whose results are either in a positive/negative or numeric format during the EHR reporting period</td>
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</table>

Provider selects and prescribes medication as needed

Provider Visit

- Review drug-to-drug and drug-to-allergy interactions
- Review patient’s insurance formulary
- Use EHR to generate prescription and transmit to pharmacy

Formulary checking is not required for Stage 1 but may have direct financial impact on the patient based upon the medications selected by provider
Using EHR medication management and e-Prescribing meets three Core objectives

Improve quality, safety, efficiency and reduce health disparities

<table>
<thead>
<tr>
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<tbody>
<tr>
<td>Use CPOE for medication orders directly entered by any licensed healthcare professional who can enter orders into the medical record per state, local and professional guidelines</td>
<td>More than 30% of unique patients with at least one medication in their medication list seen by the EP have at least one medication order entered using CPOE</td>
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<tbody>
<tr>
<td>The number of patients in the denominator that have at least one medication order entered using CPOE.</td>
<td>Number of unique patients with at least one medication in their medication list seen by the EP.</td>
<td>Patients whose records are maintained in the EHR.</td>
<td>If an EP’s writes fewer than one hundred prescriptions during the EHR reporting period</td>
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</tbody>
</table>

Using EHR medication management and e-Prescribing meets three Core objectives

Improve quality, safety, efficiency and reduce health disparities

<table>
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<tr>
<th>Objective</th>
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<tbody>
<tr>
<td>Implement drug-drug and drug-allergy interaction checks</td>
<td>The EP has enabled this functionality for the entire EHR reporting period</td>
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Requires only Yes / No Attestation

<table>
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<tr>
<td>X</td>
<td>None</td>
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Using EHR medication management and e-Prescribing meets three Core objectives

Improve quality, safety, efficiency and reduce health disparities

Objective: Generate and transmit permissible prescriptions electronically (eRx)

Standard: More than 40% of all permissible prescriptions written by the EP are transmitted electronically using certified EHR technology

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<tbody>
<tr>
<td>The number of prescriptions in the denominator generated and transmitted electronically.</td>
<td>Number of prescriptions written for drugs requiring a prescription in order to be dispensed other than controlled substances during the EHR reporting period.</td>
<td>Patients whose Records are Maintained in the EHR.</td>
<td>This objective and associated measure do not apply to any EP who writes fewer than one hundred prescriptions during the EHR reporting period.</td>
</tr>
</tbody>
</table>

Using EHR medication management and e-Prescribing meets two Menu objectives

Improve quality, safety, efficiency and reduce health disparities

**Objective**
Implement drug formulary checks

**Standard**
The EP has enabled this functionality and has access to at least one internal or external drug formulary for the entire EHR reporting period

<table>
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<tbody>
<tr>
<td>![X]</td>
<td>Any EP who writes fewer than one hundred prescriptions during the EHR reporting period should be excluded from this objective and associated measure.</td>
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</table>

Using EHR medication management and e-Prescribing meets two Menu objectives

**Improve care coordination**

**Objective**

The EP who receives a patient from another setting of care or provider of care or believes an encounter is relevant should perform medication reconciliation

**Standard**

The EP performs medication reconciliation for more than 50% of transitions of care in which the patient is transitioned into the care of the EP

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<tbody>
<tr>
<td>The number of transitions of care in the denominator where medication reconciliation was performed.</td>
<td>Number of transitions of care during the EHR reporting period for which the EP was the receiving party of the transition.</td>
<td>Patients whose Records are Maintained in the EHR.</td>
<td>If an EP was not on the receiving end of any transition of care during the EHR reporting period</td>
</tr>
</tbody>
</table>

Using EHR medication management and e-Prescribing meets two Menu objectives

**Improve care coordination**

**Objective**
The EP who receives a patient from another setting of care or provider of care or believes an encounter is relevant should perform medication reconciliation

**Standard**
The EP performs medication reconciliation for more than 50% of transitions of care in which the patient is transitioned into the care of the EP

**Transition of Care** – The movement of a patient from one setting of care (hospital, ambulatory primary care practice, ambulatory specialty care practice, long-term care, home health, rehabilitation facility) to another.
Patient completes clinical visit

Patient & Family Engagement

Pre-Visit → Registration → Patient Intake → Provider Visit → Check-Out → Post Visit

Privacy & Security
Patient receives information before leaving the practice

- Patient provided with educational information
- Patient provided with clinical summary
- Provide patients the ability to view online, download, and transmit their health information
Check-Out process meets two Core objectives

Engage patients and families in their health care

**Objective**

Provide patients the ability to view online, download, and transmit their health information within 4 business days of the information being available to the EP.

**Standard**

More than 50% of all unique patients seen by the EP during reporting period are provided timely (w/in 4 business days after the information is available to EP) online access to their health information subject to EP's discretion to withhold certain information.

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<tbody>
<tr>
<td>The number of patients in the denominator who have timely (within 4 business days after the information is available to the EP) online access to their health information.</td>
<td>Number of unique patients seen by the EP during the EHR reporting period.</td>
<td>Patients whose Records are Maintained in the EHR.</td>
<td>Neither orders nor creates any of the information listed for inclusion as part of measure, except for &quot;Patient name&quot; and &quot;Provider's name and office contact information, may exclude measure.</td>
</tr>
</tbody>
</table>

Check-Out process meets two Core objectives

Engage patients and families in their health care

Objective
Provide clinical summaries for patients for each office visit

Standard
Clinical summaries provided to patients for more than 50% of all office visits within 3 business days

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<tbody>
<tr>
<td>Number of patients in the denominator who are provided a clinical summary of their visit within three business days.</td>
<td>Number of unique patients seen by the EP during the EHR reporting period.</td>
<td>Patients whose Records are Maintained in the EHR.</td>
<td>EPs who have no office visits during the EHR reporting period</td>
</tr>
</tbody>
</table>

Check-Out process meets two Core objectives

- **Objective**
  Provide clinical summaries for patients for each office visit

- **Standard**
  Clinical summaries provided to patients for more than 50% of all office visits within 3 business days

The provider’s name and office contact information; date and location of visit; reason for visit; immunizations and/or medications administered during the visit; diagnostic tests pending; clinical instructions; future appointments; referrals to other providers; future scheduled tests; and recommended patient decision aids.
# Check-Out process meets one Menu objective

## Engage patients and families in their health care

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<tbody>
<tr>
<td>Use CEHRT to identify patient-specific education resources and provide those resources to the patient</td>
<td>More than 10% of all unique patients seen by the EP are provided patient-specific education resources</td>
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## Numerator vs. Denominator

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<th>Exclusion Criteria</th>
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</thead>
<tbody>
<tr>
<td>Number of patients in the denominator who are provided patient education specific resources.</td>
<td>Number of unique patients seen by the EP during the EHR reporting period.</td>
<td>All Unique Patients.</td>
<td>None</td>
</tr>
</tbody>
</table>

Provider has completed visit and all test results and quality indicators are complete
Consult note sent back to referring provider and key elements of structured data transmitted externally

Post Visit

- Consult note and medical summary sent to referring provider
- Immunization information is sent to State Registry
- Syndromic data is sent to Public Health organizations
- Clinical quality measures are transmitted to CMS

- CQM’s are no longer a specific core objective
- Stage 1 requires only one public health reporting menu item – Immunizations or Syndromic data
### Post visit exchange of data meets one Menu objective

**Improve care coordination**

**Objective**

The EP who transitions their patient to another setting of care or provider of care or refers their patient to another provider of care should provide summary of care record for each transition of care or referral.

**Standard**

The EP who transitions or refers their patient to another setting of care or provider of care provides a summary of care record for more than 50% of transitions of care and referrals.

<table>
<thead>
<tr>
<th>Numerator</th>
<th>Denominator</th>
<th>Population</th>
<th>Exclusion Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>The number of transitions of care and referrals in the denominator where a summary of care record was provided.</td>
<td>Number of transitions of care and referrals during the EHR reporting period for which the EP was the transferring or referring provider.</td>
<td>Patients whose Records are Maintained in the EHR.</td>
<td>If an EP does not transfer a patient to another setting or refer a patient to another provider during the EHR reporting period</td>
</tr>
</tbody>
</table>

Post visit reporting and submission of public health data may meet one of two Menu objectives

<table>
<thead>
<tr>
<th>Improve population and public health</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Objective</strong></td>
</tr>
<tr>
<td>Capability to submit electronic data to immunization registries or Immunization Information Systems and actual submission in accordance with applicable law and practice</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Requires only Yes / No Attestation</th>
<th>Exclusion Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>X</td>
<td>EPs that have not given any immunizations during the EHR reporting period are excluded from this measure.</td>
</tr>
</tbody>
</table>

Post visit reporting and submission of public health data may meet one of two Menu objectives

**Objective**
- Capability to submit electronic Syndromic surveillance data to public health agencies and actual submission in accordance with applicable law and practice

**Standard**
- Performed at least one test of certified EHR technology's capacity to provide electronic Syndromic surveillance data to public health agencies and follow-up submission if the test is successful

<table>
<thead>
<tr>
<th>Requires only Yes / No Attestation</th>
<th>Exclusion Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>X</td>
<td>If an EP does not collect any reportable syndromic information on their patients during the EHR reporting period, then they are excluded from this measure.</td>
</tr>
</tbody>
</table>

Post visit reporting and submission of CQM data

Objective: Report ambulatory clinical quality measures to CMS or the States: Must choose 9 of 64 approved CQM’s

Standard: Recommended core CQMs - encouraged but not required
- 9 CQMs for the adult population
- 9 CQMs for the pediatric population
Selected CQMs must cover at least 3 of the National Quality Strategy domains

Requires only Yes / No Attestation

Exclusion Criteria

Promoting the privacy & security of EHRs by incorporating practice policies, procedures, and password management underlies each step in the patient and visit flow.
Conduct periodic risk assessment and risk mitigation and ensure written policies are in place

- Physical security of hardware and devices
- Password management and role-based security access
- Portable and mobile device policies
- Data encryption and network security
- HIPAA compliance
Conducting periodic risk analysis and risk mitigation meets one Core objective

Ensure adequate privacy and security protections for personal health information

**Objective**
Protect electronic health information created or maintained by the certified EHR technology through the implementation of appropriate technical capabilities

**Standard**
Conduct or review a security risk analysis per 45 CFR 164.308 (a)(1) and implement security updates as necessary and correct identified security deficiencies as part of its risk management process

<table>
<thead>
<tr>
<th>Requires only Yes / No Attestation</th>
<th>Exclusion Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>X</td>
<td>None</td>
</tr>
</tbody>
</table>

Meaningful Use is built into the major components of patient visit flow and at the point of care in the clinical practice.

Using basic EHR functionality and performing common tasks can meet all Core and Menu objectives in 2014.
What Happened to Clinical Quality Measures?

The Recovery Act specifies the 3 components of Meaningful Use:

• Use of certified EHR in a meaningful manner (e.g. e-prescribing)
• Use of certified EHR technology for electronic exchange of health information to improve quality of health care
• *Use of certified EHR technology to submit clinical quality measures (CQM) and other such measures selected by the Secretary*

2014 - New CQMs in certified EHRs

• Removed as a Core Objective but required to demonstrate Meaningful Use
• Must report CQM data electronically to CMS (Medicare), or to state (Medicaid)
• 2014 CQM reporting period is the entire year or optional 3 month period identical to the reporting period for meaningful use
• Beyond 2014 the reporting period for CQMs will be the entire calendar year
• Submission period must be within 2 months following the reporting period

# How CQMs are changing

<table>
<thead>
<tr>
<th>What you did</th>
<th>What you are doing</th>
<th>What you should do</th>
</tr>
</thead>
<tbody>
<tr>
<td>Historical data based on claims collected post visit with time delay</td>
<td>Current data incorporating eRX, orders and some test results</td>
<td>CDS based on real-time ICD/CPT data, eRX, results, and approved protocols</td>
</tr>
</tbody>
</table>

**EHR Implementation and Adoption**
Submit 9 of 64 CQMs from at least 3 of 6 National Quality Standard domains: (includes adult and pediatric recommended core CQMs)

Measure harmonization goals

- Reduces burden on providers by eliminating competing measurement approaches
- Facilitates public reporting, comparisons across systems, and monitoring of progress
- Helps identify high-performers and improvements to cultivate and diffuse best practices
- May eventually support approaches in which providers are paid more for better preventive care
Agenda

What is Meaningful Use

Looking Back at EHR Implementations

How Do We Improve

Meaningful Use Road Map

Re-Thinking Meaningful Use for Success

Meaningful Use in Practice

References
References

CMS’ official website for the EHR incentive programs: www.cms.gov/EHRIncentivePrograms


National Quality Strategy: www.ahrq.gov/workingforquality/
Contact Information

Pioneer in Community Electronic Health Records

The Massachusetts eHealth Collaborative (MAeHC) delivers sustainable strategies, deep expertise, and hands-on tactical support to bring together healthcare communities and improve healthcare delivery for patients and providers. We are pioneers and innovators in tackling the most important eHealth challenges of our time.

Read More

http://www.maehc.org