MEANINGFUL USE: UNDERSTANDING STAGE 2
Who are we?

Purdue Healthcare Advisors (PHA)*, a business unit of Purdue University, specializes in affordable assistance to organizations that share our passion for healthcare transformation. We bring the latest strategies and competencies to improve care, manage margins, and facilitate compliance. Clients include health systems, provider practices, public health agencies and suppliers/vendors to the healthcare industry.

*Founded in 2005 by Purdue University, the Regenstrief Center for Healthcare Engineering, and the Indiana Hospital Association.
What is an REC, and how do we know so much about Meaningful Use?

- The Purdue REC is 1 of 62 Regional Extension Centers – grant recipients from the Office of the National Coordinator (DHHS)

- All US locations have an REC

- RECs were created to provide information, guidance, and technical assistance to health care providers to support and accelerate their efforts to become meaningful users

- RECs are helping over 150,000 providers throughout the nation

- RECs share lessons and have direct access to Federal and State resources to help providers meet MU
The Health IT Vision:

2011 – 2012: Data Capture and Sharing
- Accelerated adoption
- Data capture and exchange

2013 – 2014: Demonstrate Health System Improvement
- Widespread adoption and data exchange
- Process improvement

2015+: Transform Health Care and Population Health through Health IT
- Demonstrated improvements in care, efficiency, and population health
- Breakthrough examples of delivery and payment reform

Beyond 2015: Transformed Health Care
- Enhanced ability to study care delivery and payment systems
- Empowered individuals and increased transparency
- Improved care, efficiency, and population health outcomes

STRATEGIC GOALS
- Achieve Adoption and Information Exchange through Meaningful Use of Health IT
- Improve Care, Improve Population Health, and Reduce Health Care Costs through the Use of Health IT
- Inspire Confidence and Trust in Health IT
- Empower Individuals with Health IT to Improve their Health and the Health Care System
- Achieve Rapid Learning and Technological Advancement

*From the Office of the National Coordinator 2011-2015 Strategic Plan*
Ambulatory Progress To Date:

Figure 1. Percent of physicians with computerized capabilities to meet selected Meaningful Use Core objectives: 2009-2012

- 80% Computerized provider order entry for medication orders
- 73% E-Prescribing
- 67% Drug interaction checks
- 66% Maintain problem list
- 50% Clinical decision support rule

2012 is significantly different from 2009 for all computerized capabilities (p < 0.01).

Note: EP incentives and timing aligned with calendar year
# Incentive Payments - Medicare

<table>
<thead>
<tr>
<th></th>
<th>First Payment Received in 2011</th>
<th>First Payment Received in 2012</th>
<th>First Payment Received in 2013</th>
<th>First Payment Received in 2014</th>
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<td>Payment Amount in 2013</td>
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<td>$11,760 Reduction ($240)</td>
<td>$14,700 Reduction ($300)</td>
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<td>Payment Amount in 2014</td>
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<td>Payment Amount in 2015</td>
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<td>$3,920 Reduction ($80)</td>
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<tr>
<td>Payment Amount in 2016</td>
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<td>$1,960 Reduction ($40)</td>
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<td>TOTAL Incentive Payments</td>
<td>$43,720</td>
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Incentive Payments - Medicaid

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<tr>
<td>$83,750.00</td>
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Stage 1 Framework

- 19 measures- 14 required, 5/10 menu
- Entry level meaningful use
- Challenges include one-time tasks, group buy-in, changing workflows
- Changes in 2014 include:
  - Need 2014 certified software
  - Need patient portal for “electronic copy” measure
  - Must use 2014 clinical quality measures from different domains
Stage 2 Framework

- EP’s – 17 Core Objectives
- EP’s – 9 CQM’s from 3 NQS domains (64/6 choices)
- 3/6 Menu Objectives
- Nearly all Stage 1 retained, Menu’s moved to Core and thresholds increased
Stage 2 Selected Requirements

- CPOE labs, imaging
- Medication Reconciliation
- Patient Reminders
- Patient Access & Engagement
- Secure Messaging, Protect ePHI
- Transmission of Summary of Care Record
- Clinical Decision Support
- Clinical Quality Measures
- Progress Notes
- Accessible Scans & Tests that Result in an Image
- Family History
- Cancer Registry Reporting
- Other Registry Reporting
Medication Reconciliation

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

Denominator:
Number of transitions of care during the EHR reporting period for which the EP was the receiving party of the transition.

Numerator:
The number of transitions of care in the denominator where medication reconciliation was performed.

Threshold:
The resulting percentage must be more than 50% in order for an EP to meet this measure.
**Patient Reminders**

**Objective:**
Use clinically relevant information to identify patients who should receive reminders for preventive/follow-up care and send these patients the reminder, per the patient preference.

**Denominator:**
Number of unique patients who have had two or more office visits with the EP in the 24 months prior to the beginning of the EHR reporting period.

**Numerator:**
Number of patients in the denominator who were sent a reminder per patient preference when available during the EHR reporting period.

**Threshold:**
The resulting percentage must be more than 10% in order for the EP to meet this measure.
Patient Access & Engagement

**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.

**Denominator:**
Number of unique patients seen by the EP during the EHR reporting period.

**Numerator:**
- **Timely Access:** 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.
- **Engagement:** The number of unique patients (or their authorized representatives) in the denominator who have viewed online, downloaded, or transmitted to a third party the patient’s health information.

**Threshold:**
- Timely Access: More than 50%
- Engagement: More than 5%

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**KEY POINTS**

Replaces the electronic copy of health information objective from Stage 1

Requires 5% patient engagement; download, view, or transmit data
Secure Messaging

Objective:
Use secure electronic messaging to communicate with patients on relevant health information.

Denominator:
Number of unique patients seen by the EP during the EHR reporting period.

Numerator:
The number of patients or patient-authorized representatives in the denominator who send a secure electronic message to the EP that is received using the electronic messaging function of CEHRT during the EHR reporting period.

Threshold:
The resulting percentage must be more than 5% for an EP to meet this measure.
Objective:
Conduct or review a security risk analysis in accordance with the requirements under 45 CFR 164.308(a)(1), including addressing the *encryption/security* of data stored in CEHRT in accordance with requirements under 45 CFR 164.312 (a)(2)(iv) and 45 CFR 164.306(d)(3), and implement security updates as necessary and correct identified security deficiencies as part of the provider’s risk management process.

Attestation Requirements:
YES/NO

Risk analysis function required to place emphasis on encryption of PHI

Is not meant to replace, change, or supersede HIPAA Privacy & Security Rules
Objective:
The EP that transitions their patient to another setting of care or provider of care or refers their patient to another provider of care, provides a summary of care record for each transition of care or referral.

Measure 1:
Provide a summary of care record for more than 50% of transitions and referrals

Measure 2:
Provide a summary of care record for more than 10% of such transitions and referrals either (a) electronically transmitted using CEHRT to a recipient or (b) via NwHIN Exchange participant.

Measure 3:
The EP must satisfy one of the two following criteria: 1) conduct at least one successful exchange of a summary of care document, which is counted for measure 2 with a recipient who has a different EHR or 2) conduct at least one successful test with the CMS designated test EHR during the EHR reporting period.
Clinical Decision Support

Objective:
Implement five clinical decision support interventions related to four or more clinical quality measures at a relevant point in patient care for the entire EHR reporting period. And the EP has enabled and implemented the functionality for drug-drug and drug-allergy interaction checks for the entire EHR reporting period.

Attestation Requirements:
YES/NO

KEY POINTS

Increased from 1 CDS to 5

Includes previous drug-drug and drug-allergy objective
Clinical Quality Measures

Objective:
Starting in 2014, Eligible Professionals must report on 9 of the 64 approved CQMs. Selected CQMs must cover at least 3 of the 6 National Quality Strategy domains.

• Patient Safety
• Care Coordination
• Patient & Family Engagement
• Clinical Processes & Effectiveness
• Effective Use of Healthcare Resources
• Population & Public Health

Reporting:
2013: There are two reporting methods available for reporting the Stage 1 measures: Attestation or the eReporting pilot.

2014: All CQMs will be submitted electronically to CMS

KEY POINTS
Must report on 9 of the 64 approved measures
Must cover 3 of the 6 National Quality Strategy Domains
Electronic submission starting 2014
Meaningful Use 2014

For 2014 only:

- All EHs, CAHs, and Physicians regardless of their stage of meaningful use are only required to demonstrate meaningful use for a 3-month EHR reporting period.

- CMS is permitting this one-time 3-month reporting period in 2014 only so that all providers who must upgrade to 2014 Certified EHR Technology will have adequate time to implement their new Certified EHR systems.

- 2014 MU Adherence will determine 2015 payment adjustments.
And the Audits Begin ...

Medicare

• CMS contract with Figliozzi and Co.
• Both random and targeted; pre- and post-audits
• CMS Advice Excerpts:
  • Make sure you do a Security Risk Assessment
  • Ensure your CEHRT report has the vendor name, provider name, and time period
  • Keep good records of reports utilized for attestation
  • Have documentation of “enabled functionality” being on the entire reporting period

Medicaid

• Up to the state- follows similar protocols as Medicare
Contact us:

Allison Bryan
Managing Advisor - Special Projects
Purdue Healthcare Advisors

(765) 496-9791 (phone)
(765) 496-6990 (fax)
www.pha.purdue.edu
abryan@purdue.edu

Visit us on @Purdue Healthcare Advisors