“Achieving Stage 2 of Meaningful Use”

PRESENTED BY:

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Transformation Coach

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AHI: Who We Are

AHI is an independent, non-profit organization that partners with regional health care providers and community-based organizations to improve care, lower costs and realize a healthier future.
How We Accomplish Our Goals

1. Promote population health best practices and implementation strategies.
2. Manage programs for health advancement; and
3. Ensure individuals have access to care.
Where We Work…

9 Counties
Clinton
Essex
Franklin
Fulton
Hamilton
Saratoga
St. Lawrence
Warren
Washington

700,000
Total Population

11,000
Square Miles

9 Payors
Medicare (FSS), Medicaid, BSNENY, CDPHP, Empire BCBS, Empire UHC, Excellus, Fidelis, MVP
Our objective is to transform all safety net providers in primary care practices into NCQA 2014 Level 3 Patient Centered Medical Homes or APC models by the end of DSRIP Year 3 (March 31, 2018).

Participating practices & practitioners will be expected to meet PCMH and Meaningful Use (Stage 2), and effectively sustain this model.

AHI will be providing guidance and support while managing this project along with an administrative representative and a Physician Champion from each practice.
Original Legislation

The Health Information Technology for Economic and Clinical Health (HITECH) Act, part of the American Recovery and Reinvestment Act of 2009 (ARRA)

Goals of the HITECH Act:
• Improve patient quality of care
• Promote the adoption and meaningful use of health information technology
• Increase health information exchange
• Standardize health information technology

HITECH
Health Information Technology for Economic & Clinical Health Act
The Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs provide incentive payments to eligible professionals (EPs) as they adopt, implement, upgrade or demonstrate *meaningful use* of certified EHR technology.

There are two EHR Incentive Programs. CMS oversees the Medicare EHR Incentive Program, and the state Medicaid agencies manage the Medicaid EHR Incentive Program.
<table>
<thead>
<tr>
<th>Medicare EHR Incentive Program</th>
<th>Medicaid EHR Incentive Program</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Run by CMS</strong></td>
<td><strong>Run by Your State Medicaid Agency</strong></td>
</tr>
<tr>
<td><strong>Maximum incentive amount is $44,000</strong></td>
<td><strong>Maximum incentive amount is $63,750</strong></td>
</tr>
<tr>
<td><strong>Payments over 5 consecutive years</strong></td>
<td><strong>Payments over 6 years, does not have to be consecutive</strong></td>
</tr>
<tr>
<td>Payment adjustments will begin in 2015 for providers who are eligible but decide not to participate</td>
<td>No payment adjustments for providers who are only eligible for the Medicaid program</td>
</tr>
<tr>
<td>Providers must demonstrate meaningful use every year to receive incentive payments.</td>
<td>In the first year providers can receive an incentive payment for adopting, implementing, or upgrading EHR technology. Providers must demonstrate meaningful use in the remaining years to receive incentive payments.</td>
</tr>
</tbody>
</table>
• There are currently two Stages of Meaningful Use.
• A provider is at Stage 1 two to three years before moving to Stage 2
• The last year to attest with Medicare was 2014
• Medicaid is still accepting EPs into the program however, the provider must show 30% of patient volume is Medicaid or managed Medicaid plans
Stages of Meaningful Use

Stage 1: Data Capture and Sharing
Stage 2: Advanced Clinical Processes
Stage 3: Improved Outcomes
As of 2014, all providers must use 2014 Edition Certified EHR Technology.

• Certified by the ONC (Office of the National Coordinator for Health Information Technology)
• 2011 CEHRT no longer meets MU standards and criteria
• Contact your vendor or refer to the ONC CHPL website at http://oncchpl.force.com/ehrcert to verify you have the correct edition
• CMS published a final rule in Oct, 2015 outlining requirements for Meaningful Use – 2015 through 2017 (Modified Stage 2)
• All providers are required to attest to a single set of objectives
• There are 10 objectives, including one consolidated public health reporting objective
• The EHR reporting period for all providers will be based on the calendar year
• In 2015 only, the reporting period will be any continuous 90-day period
• For 2016 and beyond the reporting period will be the full calendar year
• Must continue to use 2014 Edition Certified EHR Technology
• Removing redundant, duplicative and topped out measures
• Modifies patient action measures
• Modifies public health reporting requirements
• Better prepare providers to report Stage 3 criteria in 2018
• Reduce provider burden and create a single set of sustainable objectives that promote best practices for patients

• Enable providers to focus on objectives, which support advanced use of health IT, such as:
  – Health information exchange
  – Consumer engagement
  – Public health reporting
1) Protect Patient Health Information
2) Clinical Decision Support
3) CPOE
4) Electronic Prescribing (eRx)
5) Health Information Exchange
6) Patient Specific Education
7) Medication Reconciliation
8) Patient Electronic Access (VDT)
9) Secure Messaging (EPs only)
10) Public Health and Clinical Data Registry Reporting
• Conduct or review a security risk analysis in accordance with the requirements of 45 CFR 164.308(a)(1), and implement security updates as necessary

• Correct identified security deficiencies as part of the risk management process
• Implement five clinical decision support interventions (related to CQMs) at a relevant point in patient care
• Enable and implement drug-drug and drug allergy interaction checks
• More than 60% of medication orders;
• More than 30% of laboratory orders;
• And, more than 30% of imaging orders are recorded using computerized provider order entry (CPOE)
More than 50% of permissible prescriptions written by the EP are queried for a drug formulary and transmitted electronically using CEHRT.
5) Health Information Exchange

• The EP that transitions or refers their patient to another setting of care or provider of care must use CEHRT to create a summary of care record
• And, electronically transmit the summary to a receiving provider for more than 10% of transitions of care or referrals
6) Patient Specific Education

• Patient specific education resources identified by CEHRT are provided to patients for more than 10% of all unique patients with office visits seen by the EP during the EHR reporting period
• 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
• More than 50% of all unique patients seen by the EP are provided timely access to view online, download or transmit their health information

• For an EHR reporting period in 2015, at least one patient seen views, downloads or transmits to a third party his or her health information
• For an EHR reporting period in 2015, the capability for patients to send and receive a secure electronic message with the EP was fully enabled during the EHR reporting period
The EP is in active engagement with a public health agency to submit:

- Immunization data;
- Syndromic surveillance data (unless the EP operates in a jurisdiction where no public health agency has declared readiness to receive data from EPs at the start of the EHR reporting period); and/or
- Specialized registry
### Objectives

<table>
<thead>
<tr>
<th></th>
<th>NY City Report To</th>
<th>NY State (outside of NY City) Report To</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Immunizations</strong></td>
<td>Citywide Immunization Registry (CIR)</td>
<td>NYS Immunization Information System (NYSIIS)</td>
</tr>
<tr>
<td><strong>Syndromic Surveillance</strong></td>
<td>NYC Department of Health and Mental Hygiene</td>
<td>*** This option is not available for EPs outside of NYC ***</td>
</tr>
<tr>
<td><strong>Specialized Disease Registry</strong></td>
<td>NYS Department of Health and Mental Hygiene</td>
<td>For Cancer Registry, New York State Cancer Registry (NYSCR)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>*** Other than Cancer Registry, this option is not available for EPs outside of NYC ***</td>
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Clinical quality measures (CQMs) are tools that help measure and track the quality of health care services.

These measures relate to long term goals for quality health care.

EPs must report 9 measures, across at least 3 different National Quality Strategy domains.
The six National Quality Strategy (NQS) domains are:

- Patient and Family Engagement
- Patient Safety
- Care Coordination
- Population/Public Health
- Efficient Use of Healthcare Resources
- Clinical Process/Effectiveness
<table>
<thead>
<tr>
<th>ID</th>
<th>CQM Title</th>
<th>Domain</th>
</tr>
</thead>
<tbody>
<tr>
<td>NQF 0018</td>
<td>Controlling High Blood Pressure</td>
<td>Clinical Process/Effectiveness</td>
</tr>
<tr>
<td>NQF 0022</td>
<td>Use of High-Risk Medications in the Elderly</td>
<td>Patient Safety</td>
</tr>
<tr>
<td>NQF 0028</td>
<td>Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention</td>
<td>Population/Health Management</td>
</tr>
<tr>
<td>NQF 0052</td>
<td>Use of Imaging Studies for Low Back Pain</td>
<td>Efficient Use of Healthcare Resources</td>
</tr>
<tr>
<td>NQF 0418</td>
<td>Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan</td>
<td>Population/Health Management</td>
</tr>
<tr>
<td>NQF 0419</td>
<td>Documentation of Current Medications in the Medical Record</td>
<td>Patient Safety</td>
</tr>
<tr>
<td>NQF 0421</td>
<td>Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up</td>
<td>Population/Health Management</td>
</tr>
<tr>
<td>CMS50v1</td>
<td>Closing the Referral Loop: Receipt of Specialist Report</td>
<td>Care Coordination</td>
</tr>
<tr>
<td>CMS90v1</td>
<td>Functional Status Assessment for Complex Chronic Conditions</td>
<td>Patient and Family Engagement</td>
</tr>
<tr>
<td>ID</td>
<td>CQM Title</td>
<td>Domain</td>
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<tr>
<td>NQF 0002</td>
<td>Appropriate Testing for Children with Pharyngitis</td>
<td>Efficient Use of Healthcare Resources</td>
</tr>
<tr>
<td>NQF 0024</td>
<td>Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents</td>
<td>Population/Public Health</td>
</tr>
<tr>
<td>NQF 0033</td>
<td>Chlamydia Screening for Women</td>
<td>Population/Public Health</td>
</tr>
<tr>
<td>NQF 0036</td>
<td>Use of Appropriate Medications for Asthma</td>
<td>Clinical Process/Effectiveness</td>
</tr>
<tr>
<td>NQF 0038</td>
<td>Childhood Immunization Status</td>
<td>Population/Public Health</td>
</tr>
<tr>
<td>NQF 0069</td>
<td>Appropriate Treatment for Children with Upper Respiratory Infection (URI)</td>
<td>Efficient Use of Healthcare Resources</td>
</tr>
<tr>
<td>NQF 0108</td>
<td>ADHD: Follow-Up Care for Children Prescribed Attention Deficit/Hyperactivity Disorder (ADHD) Medication</td>
<td>Clinical Process/Effectiveness</td>
</tr>
<tr>
<td>NQF0418</td>
<td>Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan</td>
<td>Population/Public Health</td>
</tr>
<tr>
<td>CMS75v1</td>
<td>Children Who Have Dental Decay or Cavities</td>
<td>Clinical Process/Effectiveness</td>
</tr>
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• 2014 was the last year that an EP could begin participation in the Medicare EHR Incentive Program
• 2016 is the last year that an EP can begin participation in the NY Medicaid EHR Incentive Program
• Attestation deadline is 90 days after the given payment year, ie, March 31st
CMS website for the Medicare and Medicaid EHR Incentive Programs
https://www.cms.gov/ehrincentiveprograms/
ONC Home Page http://www.healthit.gov/
NY Medicaid EHR Incentive Program website www.emedny.org/meipass

CMS Help Desk (888) 734-6433

NY Medicaid EHR Incentive Program Support Team (877) 646-5410
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