

# MEANINGFUL USE: UNDERSTANDING STAGE 2

# Who are we?

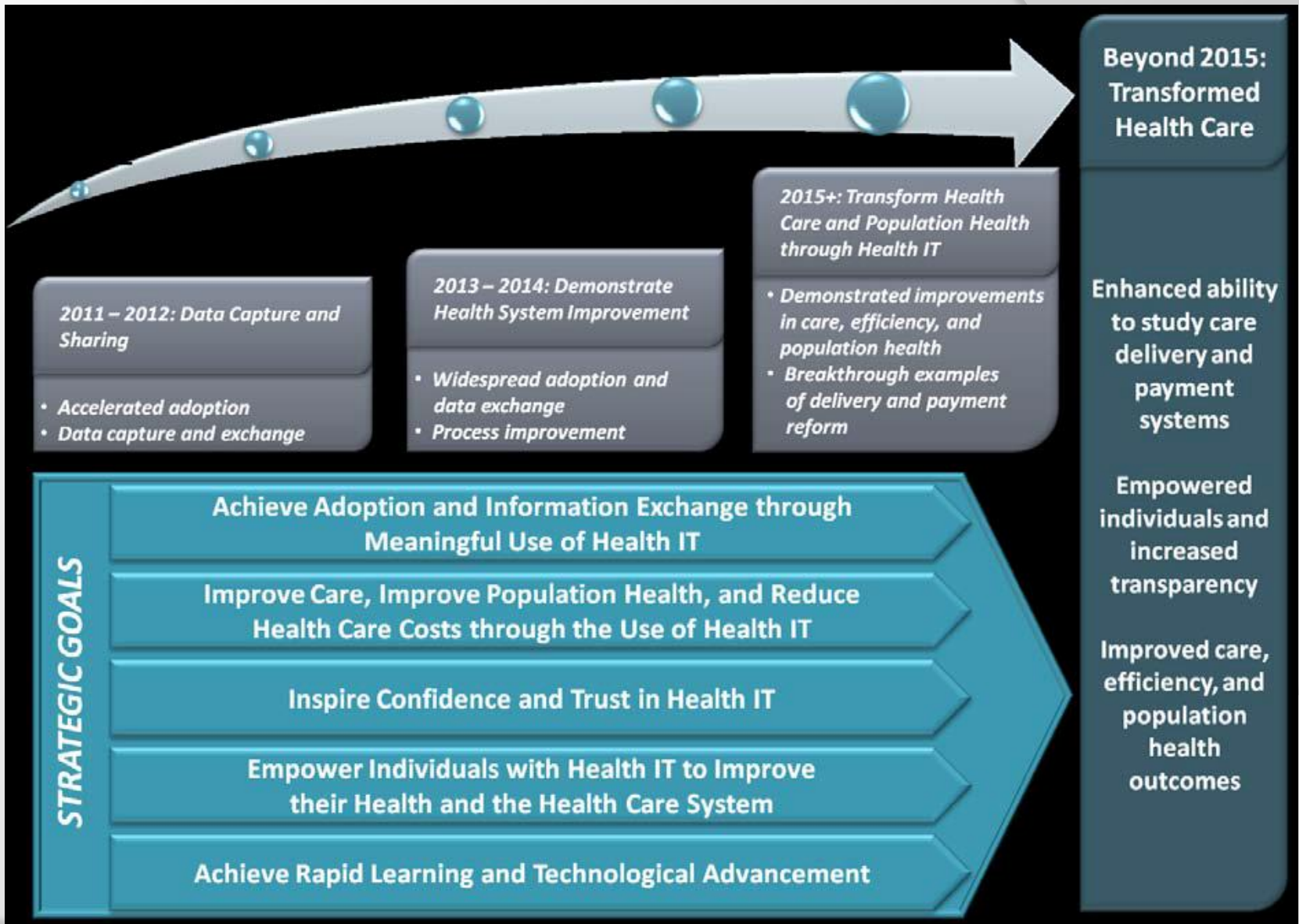
Purdue Healthcare Advisors (PHA)\*, a business unit of Purdue University, specializes in affordable assistance to organizations that share our passion for healthcare transformation. We bring the latest strategies and competencies to improve care, manage margins, and facilitate compliance. Clients include 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

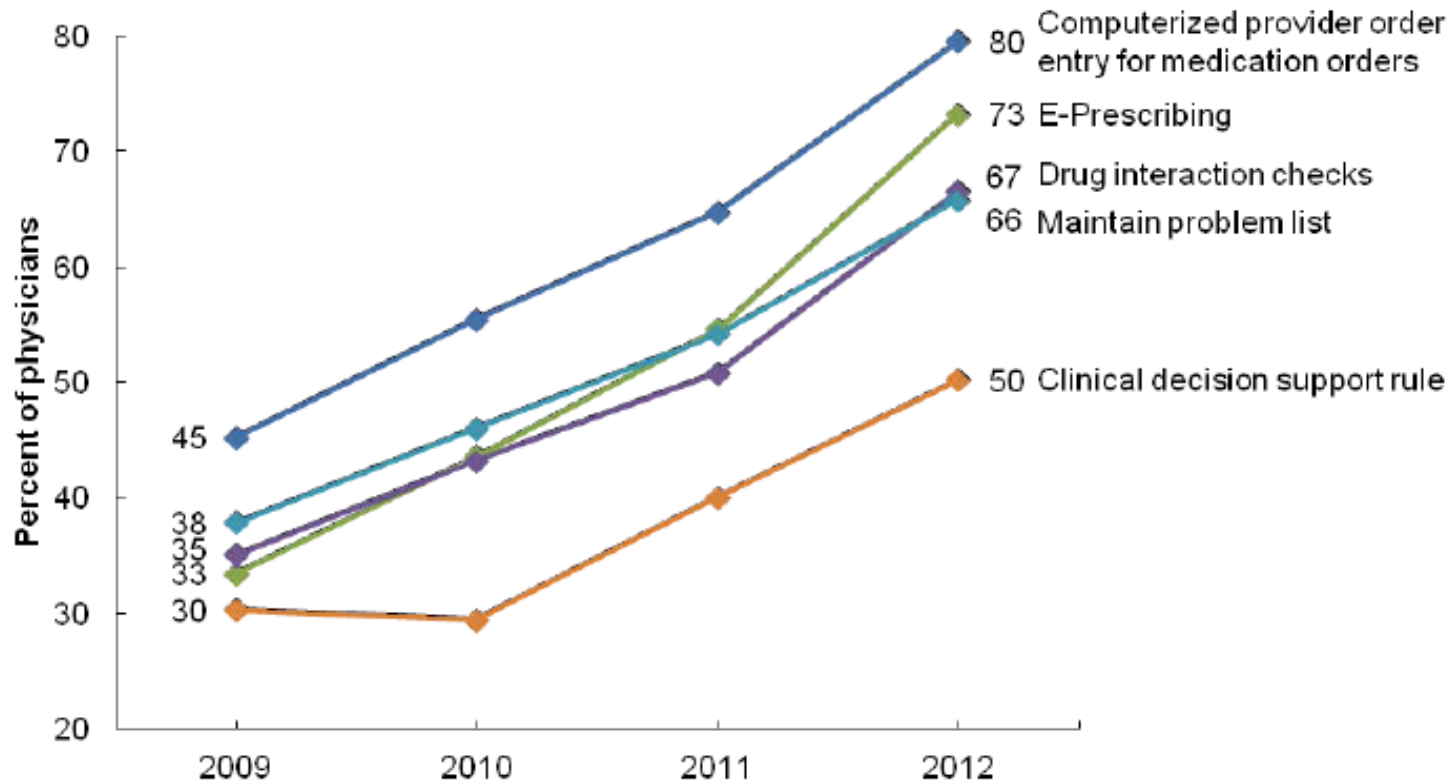
# The Health IT Vision:



*\*From the Office of the National Coordinator 2011-2015 Strategic Plan*

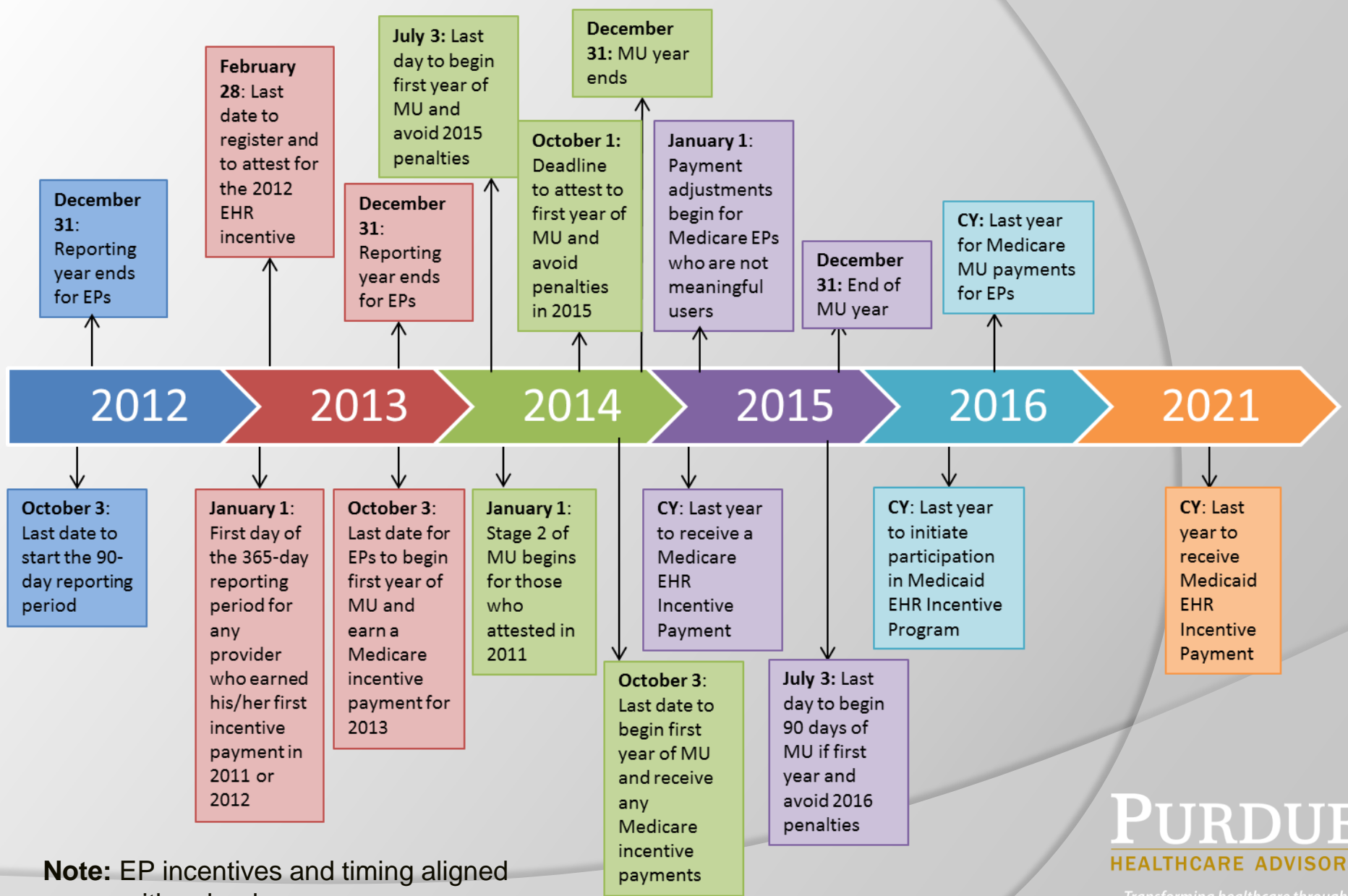
# Ambulatory Progress To Date:

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



2012 is significantly different from 2009 for all computerized capabilities ( $p < 0.01$ ).  
SOURCE: ONC analysis of 2009-2012 National Electronic Health Records Surveys.

# Eligible Professionals



**Note:** EP incentives and timing aligned with calendar year

# Incentive Payments- Medicare

	First Payment Received in 2011	First Payment Received in 2012	First Payment Received in 2013	First Payment Received in 2014
Payment Amount in 2011	\$18,000			
Payment Amount in 2012	\$12,000	\$18,000		
Payment Amount in 2013	\$7,840 Reduction (\$160)	\$11,760 Reduction (\$240)	\$14,700 Reduction (\$300)	
Payment Amount in 2014	\$3,920 Reduction (\$80)	\$7,840 Reduction (\$160)	\$11,760 Reduction (\$240)	\$11,760 Reduction (\$240)
Payment Amount in 2015	\$1,960 Reduction (\$40)	\$3,920 Reduction (\$80)	\$7,840 Reduction (\$160)	\$7,840 Reduction (\$160)
Payment Amount in 2016		\$1,960 Reduction (\$40)	\$3,920 Reduction (\$80)	\$3,920 Reduction (\$80)
TOTAL Incentive Payments	\$43,720	\$43,480	\$38,220	\$23,520





# Stage 1 Framework

- ① 19 measures- 14 required, 5/10 menu
- ① Entry level meaningful use
- ① Challenges include one-time tasks, group buy-in, changing workflows
- ① 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.

## KEY POINTS

Moved from Menu for Stage 1 to Core for Stage 2

Threshold remains at 50%

Information included is determined by the provider and patient

# 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.

## KEY POINTS



Moved from Menu for Stage 1 to Core for Stage 2

Mail, Phone, Secure Messaging when known patient preference.

# 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.

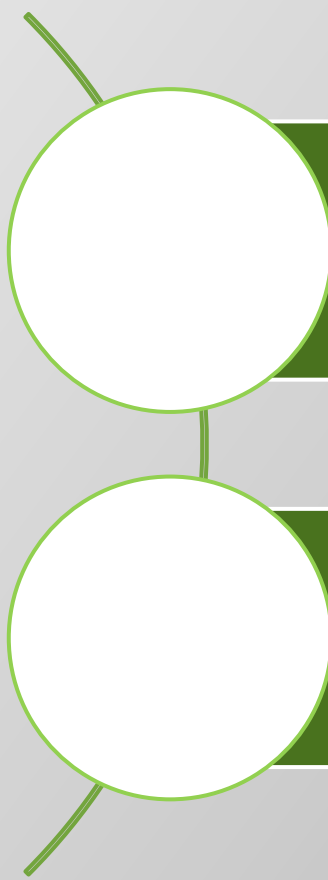
**Engagement:** The number of unique patients (or their authorized representatives) in the denominator who have viewed online, downloaded, or transmitted to a third party the patient's health information.

## Threshold:

Timely Access: More than 50%

Engagement: More than 5%

## KEY POINTS



Replaces the electronic copy of health information objective from Stage 1

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

# Secure Messaging

## KEY POINTS

### 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.



New Objective

Patients or authorized representatives can send

# Protect Electronic Health Information

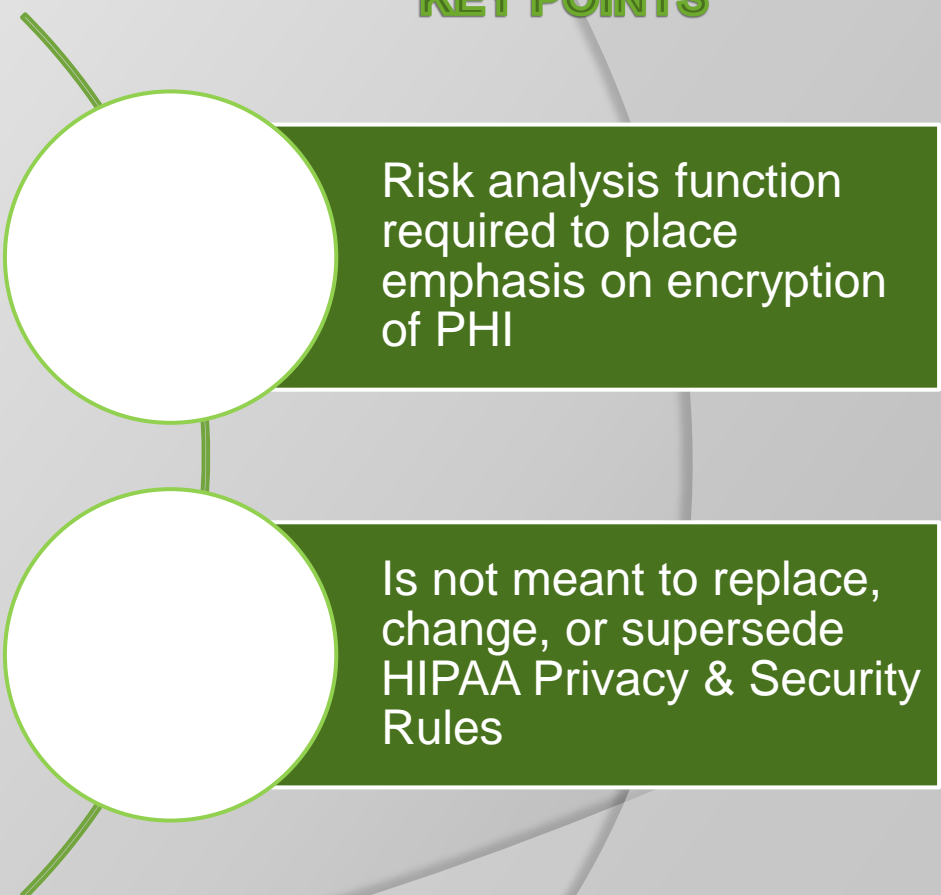
## KEY POINTS

### 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



# Summary of Care Record

## 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

## KEY POINTS

3 required measures for this objective

Requires electronic transmission for >10% of transactions

Option to conduct test with the CMS designated test EHR

# Clinical Decision Support

## KEY POINTS

### 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

Increased from 1 CDS to 5

Includes previous drug-drug and drug-allergy objective

# Clinical Quality Measures

## KEY POINTS

### 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

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 Figliozi 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](http://www.pha.purdue.edu)

[abryan@purdue.edu](mailto:abryan@purdue.edu)



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