



VEIN SPECIALISTS
OF THE SOUTH
COMPREHENSIVE VEIN CARE

Meaningful Use Stage 2 For Dummies: The Cliff notes Version

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Disclaimer:

Everything I will show can be found on the CMS Website & most is a direct quote from the CMS EHR incentive site

I just hope to make it simpler!

Most of what we will discuss today will be the Medicare Incentive

Glossary of Terms

- ▶ Functional Measures = Core + Menu
- ▶ CPOE = Computerized Provider Order Entry
- ▶ Numerator = top number of fraction
- ▶ Denominator = bottom number of fraction
- ▶ E-submit = electronic submission
- ▶ Eligible Providers = MDs and DOs (Medicaid includes NPs)
- ▶ CEHRT = Certified Electronic Health Record Technology
- ▶ First-degree relative: A family member who shares about 50% of their genes with a particular individual in a family. Usually includes: parents, offspring, and siblings

Payment Adjustments

You must attest for a 90 day period before October 1st, 2014 to avoid a penalty in 2015.

Every year you do not attest, you will receive up to a 1% penalty to accumulate a potential 5% penalty by year 2019

NO PAYMENT ADJUSTMENTS FOR MEDICAID



Hardship Exceptions for Medicare EPs

www.cms.gov/EHRIncentiveProgram

Categories:

- Infrastructure** — EPs must demonstrate that they are in an area without sufficient internet access or face insurmountable barriers to obtaining infrastructure (e.g., lack of broadband).
- New EPs** — Newly practicing EPs who would not have had time to become meaningful users can apply for a 2-year limited exception to payment adjustments. Thus EPs who begin practice in calendar year 2015 would receive an exception to the penalties in 2015 and 2016, but would have to begin demonstrating meaningful use in calendar year 2016 to avoid payment adjustments in 2017.
- Unforeseen Circumstances** — Examples may include a natural disaster or other unforeseeable barrier.

We also solicited comment on a fourth category of hardship exception as follows:

-**By Specialist/Provider Type** — EPs must demonstrate that they meet all three of the following criteria:

1. Lack of face-to-face or telemedicine interaction with patients
2. Lack of follow-up need with patients
3. Lack of control over the availability of Certified EHR Technology at their practice location. (EPs who practice at multiple locations may be granted a hardship exception solely for lack of control over the availability of Certified EHR Technology)

Stage 1 and 2: Core and Menu

MU stage 1:

15 Core Objectives

10 Menu Set Objectives, You had to select 5

MU stage 2:

17 Core Objectives–All are required

6 Menu Objectives, You much select 3

Where to go for comparison table

For Hospitals and CAHs

<http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/Stage1vsStage2CompTablesforHospitals.pdf>

For Eligible Professionals

<http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/Stage1vsStage2CompTablesforEP.pdf>

Core: Stage 1 vs 2

- | | |
|---|---|
| 1. CPOE | 1. CPOE–Med,lab, & radiology |
| 2. eRx | 2. eRx |
| 3. CQMs | 3. Demographics |
| 4. 1 clinical decision support tool | 4. Vital signs |
| 5. Electronic copy of Health information upon request | 5. Smoking status |
| 6. Clinical summaries each visit | 6. 4 clinical decision support |
| 7. Drug–drug & drug–allergy on | 7. Patient access |
| 8. Record demographics | 8. Clinical summaries |
| 9. Up–to–date problem list | 9. Protect health information |
| 10. Active medication list | 10. Lab results |
| 11. Active medication allergy list | 11. Generate patient list |
| 12. Vital signs | 12. Reminders |
| 13. Smoking status | 13. Patient–specific education |
| 14. Exchange electronic information | Resources |
| 15. Protect health information | 14. Rx reconciliation, transition of care |
| | 15. Summary of care, transition of care |
| | 16. Immunization registry |
| | 17. Secure messaging |

Menu: Stage 1 vs 2

1. Drug formulary checks
 2. Clinical lab result as structured data
 3. Generate lists of patients with specific conditions
 4. Send reminders
 5. Timely electronic access to health information
 6. Patient-specific education resources
 7. Medication reconciliation
 8. Summary of care, transition of care
 9. Immunization registry
 10. Syndromic surveillance data
1. Syndromic surveillance data
 2. Electronic notes, text searchable
 3. Imaging results, image & explanation
 4. Family history recorded as structured data
 5. Report cancer cases
 6. Report specific cases to specialized registry

CQMs: Stage 1 vs 2

2013

Report 6 out of 44

- 3 Core or Alternative Core
- 3 Menu

As of 2014

Report 9 out of 64

- 3 out of 6 NQS domains
- Recommended core CQMs
 - 9 for Adult populations
 - 9 for Pediatric populations

17 Core Objectives

Measure 1: CPOE

Stage 1 Objective

CPOE for Medication Orders

Core Item #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.

Stage 2 Objective

Use CPOE for medication, laboratory, and radiology orders

The Difference: They added laboratory and radiology in addition to % increase (see next slide)

The Threshold

Stage 1 Measure

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

Stage 2 Measure

More than 60% of medication, 30% of laboratory, and 30% of radiology of orders created by the EP are recorded using CPOE

The Difference: 60% instead of 30% for medications, and addition of 30% requirement for labs and radiology

No longer separate

Stage 1: Core 2

Implement Drug-Drug and Drug-Allergy interaction checks

Now combined with Stage 2, Core 6:
Clinical Decision Support Measure

Make sure you have enabled and implemented functionality

Measure 2: eRx

Stage 1 Objective

Generate and transmit permissible prescriptions electronically

Stage 2 Objective

SAME OBJECTIVE

No change in verbiage, but see next slide for change in threshold

The Threshold

Stage 1 Measure

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

Stage 2 Measure

More than 50% of all permissible prescriptions are compared to at least one drug formulary and transmitted electronic

The Difference: 50% instead of 40% and drug formulary is combined, no longer a separate measure

Measure 3: Record Demographics

Stage 1 Objective

Record: Preferred language, Gender, Race, Ethnicity, and Date of Birth

Stage 2 Objective

SAME OBJECTIVE

No change in verbage, but see next slide for change in threshold

The Threshold

Stage 1 Measure

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

Stage 2 Measure

More than 80% of all unique patients are recorded

The Difference: 80% instead of 50%

No longer separate

Stage 1, Core #, #, & #

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

Maintain active medication list

Maintain active medication allergy list

Now combined with Stage 2, Core #: Summary of care document at transitions of care and referrals

Measure 4: Record & Chart Vital Signs

Stage 1 Objective

Record & Chart changes in vital signs: Height, Weight, Blood Pressure, Calculate & Display BMI, Plot & Display growth charts for children 2–20 years, including BMI

Stage 2 Objective

Record & Chart changes in vital signs: Height, Weight, Blood Pressure (Age 3 & over), Calculate & Display BMI, Plot & Display growth charts for children 0–20 years, including BMI

The Difference: B/P patients 3 years and up, Option to exempt B/P & attest Ht & Wt only or Option to exempt Ht & Wt and attest B/P only

The Threshold

Stage 1 Measure

More than 50% of all unique patients age 2 and over seen by EP have blood pressure, height, and weight as structured data

Stage 2 Measure

More than 80% have blood pressure (for patients 3 and over) and height and weight (for all ages) recorded as structured data

The Difference: 80% instead of 50%, plus what is listed on previous slide

Measure 5: Smoking Status

Stage 1 Objective

Record smoking status for patients 13 years or older

Stage 2 Objective

SAME OBJECTIVE

No change in verbiage, but see next slide for change in threshold

The Threshold

Stage 1 Measure

More than 50% of all unique patients age 13 and over seen by the EP have smoking status recorded as structured data

Stage 2 Measure

More than 80% must be recorded

The Difference: 80% instead of 50%

Measure 6: Clinical Decision Support

Stage 1 Objective

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

Stage 2 Objective

Use clinical decision support to improve performance on high-priority health conditions

See next slide for change in threshold

The Threshold

Stage 1 Measure

Implement one clinical decision support rule

Stage 2 Measure

1. Implement 5 CDS interventions related to 4 or more clinical quality measures, if applicable, at a relevant point in patient care for the entire EHR reporting period
2. The EP, eligible hospital, or CAH has enabled the functionality for drug–drug and drug–allergy interaction checks for entire reporting period

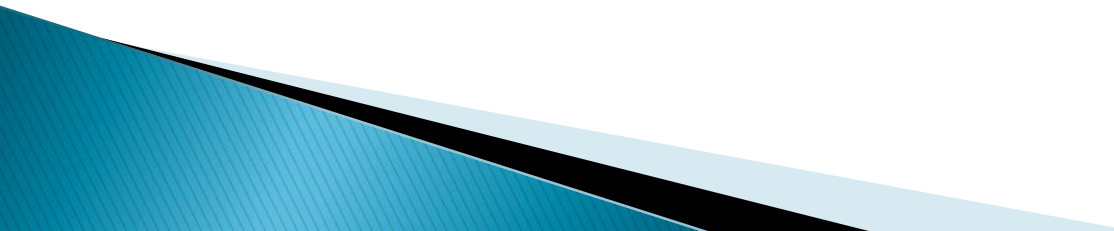
The Difference: CDS 5 vs 1 now, drug–drug and drug–allergy functionality combined

No longer separate, but still a requirement

Stage 1: Report Clinical Quality Measures (CQMs) to CMS or the States

No longer a separate objective for Stage 2.
You will still need to submit CQMs to CMS or the States in order to achieve MU

CY 2013 will still be manual submission
CY 2014 will be electronic submission



Electronically submitting CQMs

E-submit CQMs for January 1, 2014–December 31, 2014 data between the January 1, 2015 and February 28, 2015 timeframe for PQRS and EHR participation

CQMS

- ▶ Need to be electronically submitted for 2014 data
- ▶ 9 of 64 approved CQMs submitted
- ▶ 3 must cover NQS domains

There are 6 domains to choose from:

1. Patient and Family engagement
2. Patient Safety
3. Care coordination
4. Population and Public Health
5. Efficient Use of Healthcare Resources
6. Clinical Processes/Effectiveness

Measure 7: Patient Electronic Access

Stage 1 Objective

Provide patients with an electronic copy of their health information (including diagnostic test results, problem list, medication list, medication allergies) upon request

Stage 2 Objective

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

Patient Portal for success

The Threshold

Stage 1 Measure

More than 50% of all patients of the EP who request an electronic copy of their health information are provided it within 3 business days

Stage 2 Measure

More than 50% of all unique patients have online access to their health information within 4 business days after information is available to EP.

More than 5% of all unique patients seen by the EP during the EHR reporting period view, download, or transmit to a third party their health information

You need to not only have access available for the patients to get to their health information, they need to be using that access

Measure 8: Clinical Summaries

Stage 1 Objective

Provide patients clinical summaries for each office visit

Stage 2 Objective

Provide patients clinical summaries for each office visit

See next slide for change in threshold

The Threshold

Stage 1 Measure

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

Stage 2 Measure

Clinical summaries are provided to patients for more than 50% of all office visits within 1 business day

Your timeframe for delivery went from 3 business days to 1. Try to make this part of your checkout process

Are we there yet???



Elimination

Objective: Capability to exchange key clinical information (i.e. problem list, medication list, medication allergies, diagnostic test results) among providers of care and patient authorized entities electronically

Measure: Provide at least one test of certified EHR technology's capacity to electronically exchange key clinical information

Measure 9: Protect Health Information

Stage 1 Objective

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

Stage 2 Objective

No Change

See next slide for slight change

Threshold

Stage 1

Conduct or review risk analysis, implement security updates, and correct identified security deficiencies as part of risk management process

Stage 2

Same as stage 1 except addition of addressing the encryption/security of data at rest

Encryption

No longer a separate objective, but still required

Enable functionality for drug-formulary checks and have access to at least one internal or external drug formulary for the entire EHR reporting period

This is now incorporated into the e-prescribing measure for Stage 2



Measure 10: Lab results as structured data

Stage 1

Incorporate clinical lab-test results into certified EHR as structured data

Stage 2

Same as stage 1 except addition of addressing the encryption/security of data at rest

See next slide for change in threshold

The Threshold

Stage 1

More than 40% of all clinical lab tests results ordered by the EP during the EHR reporting period whose results are either positive/negative or numerical format are incorporated in certified EHR as structured data

Stage 2

More than 55% of all clinical lab tests results ordered by the EP during the EHR reporting period whose results are either positive/negative or numerical format are incorporated in certified EHR as structured data

Threshold increase to 55%

Measure 11: Generate lists of patients by specific conditions

Stage 1

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

Stage 2

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

Was previously optional. Will be required CY 2014
To make it “meaningful,” find a specific condition relative to your specialty

Measure 12: Reminders

Stage 1

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

Stage 2

Use clinically relevant information to identify who should receive reminders for preventive/follow up care

See changes. No longer optional

The Threshold

Stage 1

More than 20% of all unique patients 65 Yrs or older or 5 Yrs and younger were sent an appropriate reminder during the EHR reporting period

Stage 2

Use EHR to identify and provide reminders for preventive/follow up care for more than 10% of patients with 2 or more office visits in the last 2 years

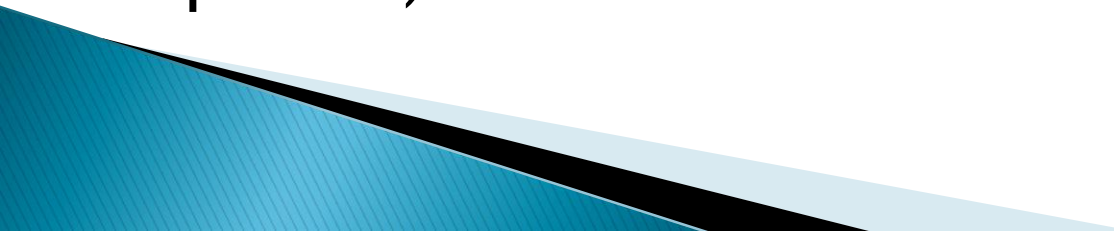
Now for all age ranges
Decrease from 20% to 10%
Patients in criteria were seen 2 times in the last 2 years

Elimination, sort of

Provide more than 10% patients seen with timely electronic access to their health information within four business days of the information being available to the EP

Eliminated from Stage 1 in 2014 and no longer an objective for Stage 2

Sort of a part of Measure 7 in Stage 2 (My opinion)



Measure 13: Use EHR to identify patient-specific education resources

Stage 1

Use certified EHR technology to identify patient-specific education resources and provide those resources to the patient if appropriate

Stage 2

Same

No longer optional. Required CY 2014 and beyond

The Threshold

The same for both Stages

10% of all unique patients seen by the EP are provided patient-specific education resources identified by the certified EHR



Measure 14: Medication Reconciliation

Stage 1

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

Stage 2

Same

No longer optional. Required CY 2014 and beyond

The Threshold

The same for both Stages

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

Measure 15: Transition of Care and Summary of Care

Stage 1

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

Stage 2

Same

No longer optional. Required CY 2014 and beyond
See next slide for 3 measures to complete within this measure

The Threshold

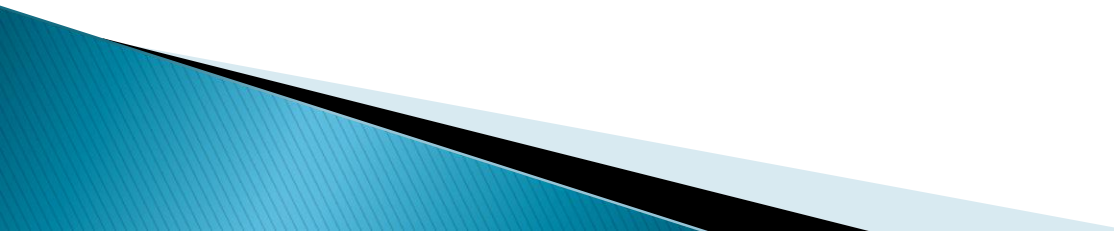
Stage 1

The EP who transitions 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

Stage 2

1. The same as above.
2. The EP provides the summary of care record either a) electronically transmitted to a recipient using the CEHRT or b) the recipient receives the summary via exchange facilitated by an organization that is a NwHIN exchange participant or through an ONC-established governance mechanism to facilitate exchange for 10% of transitions and referrals
3. The EP who transitions or refers their patient to another setting of care or provider of care must either a) conduct one or more successful electronic exchanges of a summary of care with a recipient using technology that was designed by a different EHR developer than the sender's or b) conduct one or more successful tests with the CMS-designated test EHR

3 in 1: all the changes

- ▶ Required as of CY 2014
 - ▶ 1st: More than 50% who are referred must have a summary of care sent with the referral
 - ▶ 2nd: 10% of referrals and summaries of care must be sent electronically via exchange or other method within the EHR
 - ▶ 3rd: One transmission must be sent electronically to a different EHR vendor or the CMS designated Test EHR
- 

Measure 16: Capability to submit to immunization registries/systems

Stage 1

Capability to submit electronic data to immunization registries or immunization information systems and actual submission except where prohibited, and in accordance with applicable law and practice

Stage 2

Same

No longer optional. Required CY 2014 and beyond
Know your jurisdiction's immunization registries/systems

Measure 17: NEW

Use secure messaging to communicate with patients

Objective:

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

Measure:

A secure message was sent using the electronic messaging function of the CEHRT by more than 5 percent of unique patients (or their authorized representative)

MENU Objectives

You must select 3 of the 6

BEWARE: Just because you claim an exclusion doesn't mean it will count towards your 3...Quite the contrary

Menu Measure 1: Syndromic surveillance data

Stage 1

Capability to submit electronic syndromic surveillance data to public health agencies and actual submission except where prohibited and in accordance with applicable law and practice

Stage 2

SAME



The Threshold

Stage 1

Performed at least one test of EHR's capability to provide electronic syndromic surveillance data

Stage 2

Successful ongoing submission of data

Note: State of GA is still excluded from this requirement. If I claim the exclusion, it still does not count towards my 3 menu objectives required

Menu Measure 2: NEW–Record electronic notes in patient records

Objective:

Record electronic notes in patient records.

Measure:

Enter at least 1 electronic progress note created, edited, and signed by an EP for more than 30% of unique patients with at least 1 office visit during the EHR reporting period. The text must be searchable and may contain drawings and other content

Menu Measure 3: NEW–Imaging results & information accessible

Objective:

Imaging results consisting of the image itself & any explanation or other accompanying information are accessible through CEHRT

Measure:

More than 10% of all tests whose result is one or more images ordered by the EP during the EHR reporting period are accessible through the CEHRT

Menu Measure 4: NEW–Record patient family HX as structured data

Objective:

Record patient family history as structured data

Measure:

More than 20% of all unique patients seen by the EP during the EHR reporting period have a structured data entry for one or more first-degree relatives

It is acceptable to select “Unknown,” if truly unknown

First-degree relative: A family member who shares about 50% of their genes with a particular individual in a family. Usually includes: parents, offspring, and siblings

Menu Measure 5: Capability to report Cancer cases

Objective:

Capability to identify and report cancer cases to a public health central cancer registry, except where prohibited, and in accordance with applicable law and practice

Measure:

Successful ongoing submission of cancer case information from CEHRT to a cancer registry for entire EHR reporting period

Menu Measure 6: Report specific cases to specialized registry

Objective:

Capability to identify and report specific cases to a specialized registry (other than cancer registry), except where prohibited, and in accordance with applicable law and practice

Measure:

Successful ongoing submission of specific case information from CEHRT to a specialized registry for the entire EHR reporting period