MEANINGFUL USE

Information taken from www.cms.gov/emr

CMS QUALITY IMPROVEMENT PROGRAMS

CMS = Centers for Medicare and Medicaid Services

- Medicare EHR Incentive Program (Meaningful Use)
- Physician Quality Reporting System (PQRS) may also participate in PQRS
- Medicare Improvements for Patients and Providers Act (MIPPA) e-prescribing Incentive Program

How much money you get depends on when you start reporting

WHAT IS MEANINGFUL USE?

- Medicare and Medicaid EHR incentive program
- Used to improve care coordination
- Improve quality, safety, efficiency, and reduce health disparities
- Engage patients and families in their health care
- Improve population and public health
- Maintain privacy and security

WHO IS ELIGIBLE?

- All MDs, DOs, and ODs you work for
- Doctors cannot be hospital based (must see 90% or more of their patients in the office)
- Also DDS, DMD, CNP, PA, DC, DPM, CNM

Wanda Heath, BS, COT, CCRC
Director of Clinical Services
Horizon Eye Care
Charlotte, NC
2014
**The Carrot or the Stick?**

- Better patient care
- Document public health
- Improved work flow
- Mandated in law
- Incentives
- Penalties

**What Do I Have to Do?**

- First, select and implement a Certified EHR
- Register for attestation of the CMS web-based system: [https://ehrincentives.cms.gov](https://ehrincentives.cms.gov)
- Report data on a continuous 90-day period

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**The 3 Stages of Meaningful Use**

3 elements of meaningful use require the use of a certified EHR

1. In a meaningful manner (e.g., e-prescribing)
2. For electronic exchange of health information with the objective of improving the quality of health care
3. To submit clinical quality and other measures

**Stage 1: Data Capturing and Sharing**

- Bonus program began in 2011
- Participation must begin no later than 10/3/14 to receive incentives
- Focused on providers capturing patient data and sharing that data either with the patient or with other healthcare professionals
- Report on all 13 of a Core Set Objectives and Measures AND report 5 of 10 Menu Set Objectives and Measures (one of which must address public health), AND report 9 Clinical Quality Measures

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**Meaningful Use: Core Objectives**

1. Computerized Provider Order Entry
2. Drug-drug and drug-allergy interaction checks
3. Maintain up-to-date problem list of current and active diagnoses
4. E-Prescribing
5. Maintain active medication list
6. Maintain active medication allergy list
7. Record demographics
8. Record and chart changes in vital signs
9. Record smoking status for patients 13 years or older
10. Implement one clinical decision support rule
11. Provide patients the ability to view online, download and transmit their health information
12. Provide clinical summaries for patients for each office visit
13. Protect electronic health information

*new for 2014*

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**Meaningful Use: Core Objectives**

1. Use CPOE

Record, change, and access:

- Medications
- Laboratory
- Radiology/Imaging
Beginning in 2013, in any stage, they are allowing only "externally credentialed" individuals to enter orders for the EP

**MEANINGFUL USE: CORE OBJECTIVES**

2. Implement drug-drug and drug-allergy interaction checks

Instant information of patient allergies. If you documented a sulfa allergy in your patient’s electronic chart, any time a prescription for a medication with sulfa is logged in, an alert pops up.

**MEANINGFUL USE: CORE OBJECTIVES**

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

More than 80 percent of all unique patients seen must have at least one entry or an indication that no problems are known for the patient

**MEANINGFUL USE: CORE OBJECTIVES**

4. Generate and transmit permissible prescriptions electronically (eRx)

More than 40 percent of all permissible prescriptions (not schedule 2) must be transmitted electronically using certified EHR technology. Exclusion: Any EP who writes fewer than 100 prescriptions during the EHR reporting period.

**MEANINGFUL USE: CORE OBJECTIVES**

5. Maintain an active medication list

More than 80 percent of patients seen by the provider must have at least one medication entry (or an indication that the patient is not currently prescribed any medication) recorded as structured data

**MEANINGFUL USE: CORE OBJECTIVES**

6. Maintain an active medication allergy list

More than 80 percent of all unique patients seen by the provider must have at least one medication entry (or an indication that the patient has no known allergies) recorded as structured data.
MEANINGFUL USE: CORE OBJECTIVES

7. Record demographics

Record all of the following demographics: preferred language, gender, race, ethnicity, date of birth. More than 50 percent of all unique patients need to have demographics recorded as structured data.

8. Record Vital Signs

More than 50% of all unique patients seen by the provider during the reporting period have blood pressure (for patients age 3 and over) and height and weight (for all ages) recorded.

9. Record Smoking Status

More than 50% of all unique patients 13 years old or older seen by the provider during the reporting period have smoking status recorded.

10. Clinical Decision Support Rule

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

11. Provide patients the ability to view online, download, and transmit their health information

More than 50% of all unique patients are provided timely (within 4 business days after the information is available to the EP) online access to their health information subject to the EP’s discretion to withhold certain information.

12. Clinical Summaries

Clinical summaries provided to patients for more than 50% of all office visits within 3 business days.
**MEANINGFUL USE: CORE OBJECTIVES**

13. Protect Electronic Health Information

Conduct a security risk analysis and implement security updates as necessary.

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**MEANINGFUL USE: MENU OBJECTIVES**

You must report on 5 of the 9 menu options

- At least one of the 5 must be a Public Health objective

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**MEANINGFUL USE: MENU OBJECTIVES**

Public Health Directives:

1. Submit electronic data to immunization registries
2. Submit electronic syndromic surveillance data to public health agencies

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**MEANINGFUL USE: MENU OBJECTIVES**

Public Health Directives:

1. Submit electronic data to immunization registries
   - Perform at least one test of EHR’s capacity to submit electronic data to immunization registries and follow up submission if the test is successful

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**MEANINGFUL USE: MENU OBJECTIVES**

Public Health Directives:

2. Submit electronic syndromic surveillance data to public health agencies
   - Perform at least one test of EHR’s capacity to provide electronic syndromic surveillance data

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**MEANINGFUL USE: MENU OBJECTIVES**

3. Drug formulary checks
4. Incorporate clinical lab-test results
5. Generate lists of patients by specific conditions
6. Send reminders to patients for preventive/follow-up care
7. Patient-specific education resources
8. Medication reconciliation
9. Summary of care record for transitions of care
MEANINGFUL USE: MENU OBJECTIVES

3. Drug formulary checks
Enable the functionality on the EHR and access at least one external formulary for the entire reporting period

4. Incorporate clinical lab-test results
More than 40% of all clinical lab test results ordered by the physician must be documented in EHR

5. Generate lists of patients by specific conditions
Generate at least one report listing patients with a specific condition

6. Send reminders to patients for preventive/follow-up care
More than 20% of all patients 65 years or older or 5 years old or younger were sent a reminder during the reporting period

7. Patient-specific education resources
More than 10% of all unique patients seen are provided patient-specific education resources

8. Clinical information reconciliation
Perform electronic reconciliation for more than 50% of transitions of care in which the patient is transitioned into the care of the provider
MEANINGFUL USE: MENU OBJECTIVES
• Summary of care record for transitions of care

A provider 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.

MEANINGFUL USE: MENU OBJECTIVES
• It is possible that none of the menu objectives are applicable to your scope of practice. If that is the case for you and you qualify for all of the exclusions for each of the menu objectives, then you can select 5 menu objectives and claim the exclusion for each.
• However, if you do not qualify for all of the exclusions to the menu objectives, you should go back and select menu objectives on which you can report.

MEANINGFUL USE: CLINICAL QUALITY MEASURES
Report Ambulatory Clinical Quality Measures to CMS
• If in your 1st year of demonstrating MU:
  • Attest to 9 of the 64 approved CQMs
  • Selected CQMs must cover at least 3 of the 6 Nationally Quality Strategy domains
    • Patient and Family Engagement
    • Patient Safety
    • Care Coordination
    • Population and Public Health
    • Efficient Use of Healthcare Resources
    • Clinical Processes/Effectiveness
• If the provider is beyond their 1st year of demonstrating MU:
  • Report 9 CQMs covering at least 3 NQ8 domains electronically to CMS
  • OR, satisfy requirements of PQRS reporting options using EHR

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CORe OBIective: CQM Core Measures
1. NQF 0013: Hypertension: Blood Pressure Measurement
   • The percentage of patient visits with blood pressure measurement recorded among all patient visits for patients over 18 years of age with diagnosed hypertension

2. NQF0028: Preventive Care and screening Measure Pair:
   • Tobacco Use Assessment
   • Tobacco Cessation Intervention
     • The percentage of patients aged 18 years and older who have been seen for at least 2 office visits who were queried about tobacco use one or more times within 24 months
     • The percentage of patients aged 18 years and older identified as tobacco users within the past 24 months and have been seen for at least 2 office visits who received cessation intervention

3. NQF 0421/PQRS 128: Adult Weight Screening and Follow-up
   • The percentage of patients aged 18 years and older with a calculated BMI in the past six months or during the current visit documented in the medical record AND if the most recent BMI is outside parameters, a follow-up plan is documented

<table>
<thead>
<tr>
<th>Clinical Quality Measure Title</th>
<th>NQF Measure Number &amp; PQRI Implementation Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Weight Assessment and Counseling for Children and Adolescents</td>
<td>NQF 0024</td>
</tr>
<tr>
<td>Preventive Care and Screening: Influenza Immunization for Patients 50 Years Old or Older</td>
<td>NQF 0014 PQRI 1 10</td>
</tr>
<tr>
<td>Childhood Immunization Status</td>
<td>NQF 0038</td>
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</tbody>
</table>

You can find more information on these and other clinical quality measures on our [website](http://www.who.gov/clinicalqualitymeasures).

2014 CQMs

<table>
<thead>
<tr>
<th>Measure</th>
<th>Domain</th>
</tr>
</thead>
<tbody>
<tr>
<td>0002</td>
<td>Feeding and Care for Children with Rheumatologic Conditions</td>
</tr>
<tr>
<td>0004</td>
<td>Infection and Management of Infection and Other Drug Use disorders</td>
</tr>
<tr>
<td>0010</td>
<td>Controlling High Blood Pressure</td>
</tr>
<tr>
<td>0022</td>
<td>Use of High-Risk Medications in the Elderly</td>
</tr>
<tr>
<td>0024</td>
<td>Weight Management for Patients with Nutrition and Physical Activity for Children and Adolescents</td>
</tr>
<tr>
<td>0025</td>
<td>Preventive Care and Counseling: Tobacco Use and Smoking Cessation Intervention</td>
</tr>
<tr>
<td>0031</td>
<td>Breast Cancer Screening</td>
</tr>
<tr>
<td>0032</td>
<td>Colorectal Screening</td>
</tr>
<tr>
<td>0035</td>
<td>Cholesterol Screening for Women</td>
</tr>
</tbody>
</table>

*Recommended Adult Clinical Quality Measure **Recommended Pediatric Clinical Quality Measure
Attestation is a legal statement that you have met the thresholds and all of the requirements of the Medicare EHR Incentive Program. The process of attestation happens through an internet-based CMS system that allows you to enter information on all of the following:

- 13 core objectives
- 5 out of 10 menu objectives
- 9 out of 64 clinical quality measures from at least 3 of the 6 key health care policy domains
HOW TO ATTEST

- You will attest through the same system where you initially registered: https://ehrincentives.cms.gov
- During the attestation process, you will enter data and answer yes/no questions on the core objectives, menu objectives, and clinical quality measures.

HOW TO ATTEST

You can practice:
- The Meaningful Use Attestation Calculator allows you to see the language used during attestation and to enter your core and menu objective information to see if you have met all of the requirements for the Medicare EHR Incentive Program.
- go to http://www.cms.gov/apps/ehr

AFTER ATTESTATION

- As soon as you submit your attestation, you will find out immediately whether or not you have successfully achieved the core and menu objectives of the program.
- If you are not successful, you can edit any information that was entered incorrectly and resubmit your attestation. Or you can resubmit for a different 90-day reporting period with new information.
- If you are successful, CMS will perform a number of internal checks to be sure you are eligible for payment. You should then receive your EHR incentive payment in approximately 4-8 weeks following attestation.

MU STAGE 2

- All providers must achieve meaningful use under the Stage 1 criteria before moving to Stage 2
- Intent: save money, time, and lives by improving care through better clinical decision support, care coordination and patient engagement
- Report on 17 core objectives and 3 out of a possible 6 menu objectives
- Even if you already have a certified EHR, you will have to adopt or upgrade to the new certification in order to participate in 2014

MU STAGE 2

- Because all providers must upgrade or adopt newly certified EHRs in 2014, all providers regardless of their stage of MU are only required to demonstrate MU for a 3 month (90 day) reporting period in 2014
  - Jan 1-March 31
  - April 1-June 30
  - July 1-September 30
  - October 1-December 31
MU STAGE 2

- After you have demonstrated MU under the Stage 1 requirements, you will have to demonstrate MU under the Stage 2 requirements

17 core measures + 3 menu measures + CQMs = Stage 2 of meaningful use

MU STAGE 2 CORE

1. Computerized Provider Order Entry (CPOE)

Stage 1 said: Enter at least one medication into the EMR for more than 30% of all unique patients
Stage 2 says: Use CPOE to enter at least 60% of meds, 30% of lab orders, and 30% of radiology orders

2. E-Prescribing (eRx)

Stage 1 said: More than 40% of prescriptions must be transmitted electronically using certified EHR technology.
Stage 2 says: More than 50% of all permissible prescriptions are compared to at least one drug formulary and transmitted electronically.

3. Record Demographics

Stage 1 said: Record all of the following demographics: preferred language, gender, race, ethnicity, date of birth for more than 50% of all unique patients.
Stage 2 says: Record for more than 80%

4. Record Vital Signs

Stage 1 said: Record BP, height, and weight for more than 50% of patients
Stage 2 says: Record for more than 80%
MU Stage 2

5. Record smoking status for patients 13 years or older

Stage 1 said: Record smoking status for more than 50% of all patients 13 years old or older

Stage 2 says: Record for more than 80% of patients

MU Stage 2

6. Use clinical decision support

Stage 1 said: Implement one clinical decision support rule

Stage 2 says: Implement 5

MU Stage 2

7. Provide patients the ability to view online, download, and transmit their health information

Stage 1 said: More than 50% of all patients who request an electronic copy of their health information are provided it within 3 business days

Stage 2 says:
  o More than 50% of patients are provided online access to their health information within 4 business days AND
  o more than 5% of patients view, download, or transmit to a third party their health information

MU Stage 2

8. Provide clinical summaries for patients for each office visit

Stage 1 said: Provide clinical summaries to patients for more than 50% of all office visits within 3 business days

Stage 2 says: Provide for 50% of all office visits within one business day

MU Stage 2

9. Protect electronic health information

Stage 1 said: Conduct a security risk analysis and implement security updates as necessary

Stage 2 says: Conduct a security risk analysis and implement security updates as necessary

MU Stage 2

10. Incorporate clinical lab-test results into EHR technology

Stage 1 said: (Menu item) Document more than 40% of all clinical lab test results in EHR

Stage 2 says: Document more than 55%
11. Generate lists of patients by specific conditions

Stage 1 said: (Menu item) Generate at least one report listing patients with a specific condition

Stage 2 says: Generate at least one report listing patients with a specific condition

12. Identify patients who should receive reminders for preventive/follow-up care

Stage 1 said: (Menu item) Send a reminder to more than 20% of all patients 65 years or older or 5 years old or younger

Stage 2 says: Send a reminder to more than 10 percent of all patients who have had 2 or more office visits within 24 months

13. Identify patient-specific education resources and provide those resources to the patient

Stage 1 said: (Menu item) Provide patient-specific education resources to more than 10% of all patients

Stage 2 says: Provide patient-specific education resources to more than 10% of all patients

14. Perform medication reconciliation

Stage 1 said: (Menu item) Perform medication reconciliation for more than 50% of transitions of care in which the patient is transitioned into the care of the provider

15. Provide summary of care record for each transition of care or referral

Stage 1 said: (Menu item) A provider 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

Stage 2 says satisfy both:
- Provide a summary for 50% of transitions of care and
- 10% of those summary of care transitions must be transmitted electronically

Satisfy one of the following:
- Must successfully transmit one or more of the summary of care documents with a recipient who has a different EHR program
- Conduct one or more successful tests with the CMS designated test EHR

16. Immunization registries data submission

Stage 1 said: (Menu item) Perform at least one test of EHR’s capacity to submit electronic data to immunization registries and follow up submission if the test is successful

Stage 2: Successful ongoing submission of electronic immunization data to an immunization registry
MU Stage 2

17. Use secure electronic messaging to communicate with patients

Stage 1 said: Not addressed

Stage 2 says: Communicate with patients with a secure message sent using the electronic messaging function of the EHR on more than 5% of unique patients seen during the reporting period

MU Stage 2 Menu Objectives

Must select 3 of 6:
1. Submit electronic syndromic surveillance data
2. Record electronic notes in patient records
3. Imaging and results are accessible through CEHRT
4. Record patient family health history as structured data
5. Identify and report cancer cases to a public health registry
6. Identify and report specific cases to a public health registry

MU Stage 2 Menu Objectives

2. Record electronic notes in patient records

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

MU Stage 2 Menu Objectives

3. Imaging and results are accessible through CEHRT

More than 10% of all scans and tests whose result is an image ordered by the EP for patients seen during the EHR reporting period are incorporated into or accessible through Certified EHR Technology

MU Stage 2 Menu Objectives

4. Record patient family health history as structured data

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 or an indication that family health history has been reviewed

MU Stage 2 Menu Objectives

5. Identify and report cancer cases to a public health registry
MU STAGE 2 MENU OBJECTIVES

6. Identify and report specific cases to a public health registry

2013 Measures Requiring Data Submission

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<th>Menu</th>
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<td>Reminders provided</td>
</tr>
<tr>
<td>E-prescriptions (eRx)</td>
<td>Timely electronic access</td>
</tr>
<tr>
<td>Active medication list</td>
<td>Education Provided</td>
</tr>
<tr>
<td>Active allergy list</td>
<td>Medication reconciliation</td>
</tr>
<tr>
<td>Record demographics</td>
<td>Summary of care record for transitions out of care</td>
</tr>
<tr>
<td>Record vital signs</td>
<td></td>
</tr>
<tr>
<td>Record smoking status</td>
<td></td>
</tr>
<tr>
<td>Provide electronic copy of health information</td>
<td></td>
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<tr>
<td>Provide clinical summary</td>
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2014 Measures Requiring Data Submission

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KEEP AN AUDIT FILE!

- Keep documentation for every measure and retain for 6 years post-attestation
- Take screen shots at the beginning of the attestation period, in the middle, and at the end
- All screen shots must show the EMR product name
- Be sure the date and time show in your screen shots
- DO NOT show PHI in screen shots
- Keep a copy of office policies and procedures with your audit documentation
- Provide a copy of the Office of the National Coordinator of Health Information Technology (ONC) certification
- Provide licensing agreements with the vendor or invoices from the time the system was purchased
- Include your security risk analysis

AUDIT

- At how many offices/facilities do you see your patients?
- Do you utilize EHR software in all of these facilities?
  - 50% or more patient encounters during the reporting period must occur at a location with a certified CPOE
- If you are providing a summary report from your EHR, be sure the report identifies it was created by the EHR

SUMMARY

MU 2 vs. MU1
Core and Menu Objectives

<table>
<thead>
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<th>STAGE 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eligible Professionals</td>
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</tr>
<tr>
<td>14 core objectives</td>
<td>17 core objectives</td>
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<tr>
<td>5 of 10 menu objectives</td>
<td>3 of 6 menu objectives</td>
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<td>20 total objectives</td>
<td>20 total objectives</td>
</tr>
<tr>
<td>Eligible Hospitals &amp; CAHs</td>
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</tr>
<tr>
<td>14 core objectives</td>
<td>17 core objectives</td>
</tr>
<tr>
<td>5 of 10 menu objectives</td>
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<tr>
<td>19 total objectives</td>
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SUMMARY

MU 2 vs. MU1
Clinical Quality Measures

<table>
<thead>
<tr>
<th>PRIOR TO 2014</th>
<th>2014 AND BEYOND</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eligible Professionals</td>
<td>Eligible Professionals</td>
</tr>
<tr>
<td>6 out of 84</td>
<td>9 out of 94</td>
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<tr>
<td>3 Core of 74 Core</td>
<td>At least 1 in 3 NGOS domains</td>
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<td>6 Additional</td>
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<tr>
<td>Eligible Hospitals &amp; CAHs</td>
<td>Eligible Hospitals &amp; CAHs</td>
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<td>14 out of 28</td>
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<tr>
<td></td>
<td>At least 1 in 2 NGOS domains</td>
</tr>
</tbody>
</table>

RESOURCES

- CMS MU Homepage: https://www.cms.gov/EHRIncentivePrograms/
- For additional information or questions the CMS EHR desk can be contacted directly at 1-888-734-6433

RESOURCES