Targeting Next Stages of Meaningful Use

Community Health Institute
Massachusetts League of Community Health Centers
May 6, 2015
John Cupples, Principal
Cupples Associates Consulting, LLC
Meaningful Use: Current Status

- Stage 1 MU: Interoperable EHR
- Stage 2 MU: Data Capturing and Sharing
- Stage 3 MU: Advanced Clinical Processes
- Improved Outcomes

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2014 Medicaid Attestation “Grace” Period extends to June 24, 2015—but your submission schedule should be the “sooner the better.”

On 4/15/2015 CMS issued proposed new rules affecting Meaningful Use for 2015 through 2017 for a 60-day comment period.

The proposed rules are expected to become final in this summer.
Meaningful Use: Lots of Things To Do

• Current priorities (should be):
  • Finish 2014 Attestation in MAPIR.
  • Keep up with AIU Attestation for new providers, if eligible.
  • Check with EHR vendors about modifications to your MU reports to comply with the 2015 Rules—begin monitoring the performance of your Eligible Providers.
  • Get Dentists started down the MU journey (or study impact of proposed 2015 CMS Rules).
  • Stepping up ePHI protection and risk assessment processes.
  • Don’t forget about Massachusetts Chapters 305 and 224.
  • Build your MU Audit Documentation Books!!!
The 2015 CMS Rule: Overview

- 90-Day reporting period for CY 2015.
- In 2016, only EPs beginning at Stage 1, Year 1 will be eligible to use the 90-Day Period.
- The Measures (outlined in subsequent slides) are in effect 2015 – 2017 for all EPs attesting to Stage 1 and 2 (with some options for Stage 1 EPs).
- CQMs remain the same as in the 2014 version: Report on 9/64, spread over 3 domains. If reported by Attestation, can be any 90 day or greater period from same CY.
- These Measures were “field tested” with rather positive results.
A number of measures are eliminated:
- Record Demographics
- Record Vital Signs
- Record Smoking Status
- Clinical Summaries *(but not quite)*
- Structured Lab Results
- Patient List
- Patient Reminders *(needs examination)*
- Summary of Care *(Paper version)*
- Electronic Notes
- Imaging Results
- Family Health History
## 2015 – 2017 Objectives

<table>
<thead>
<tr>
<th>No</th>
<th>Objective</th>
<th>Measure(s)</th>
<th>Denominator</th>
<th>Threshold</th>
<th>Stage 1 Alt</th>
</tr>
</thead>
</table>
| 1  | CPOE                       | • Medication Orders via CPOE  
• Lab Orders  
• Imaging Orders | • Orders  
• Orders  
• Orders | >60%  
>30%  
>30% | • >30%  
• Exclusion  
• Exclusion |
| 2  | eRx                        | Query **Formulary** and Transmit electronically. | Rx              | >50%      | >40% eRx only             |
| 3  | Clinical Decision Support  | • Implement 5 CDS Interventions  
• Enable Drug/Drug & Drug/Allergy | N/A             | Y/N Y/N   | Implement 1 CDS Rule      |
| 4  | Patient eAcess             | • Patient 4-Day eAccess to PHI  
• 1 Patient VDTs | Unique Pts.  
1 patient | >50%  
1 Pat. | • >50%  
• Exclusion |
## 2015 – 2017 Objectives - 2

<table>
<thead>
<tr>
<th>No</th>
<th>Objective</th>
<th>Measure(s)</th>
<th>Denominator</th>
<th>Threshold</th>
<th>Stage 1 Alt</th>
</tr>
</thead>
<tbody>
<tr>
<td>5</td>
<td>Protect PHI</td>
<td>Conduct or Review Security Risk Analysis</td>
<td>N/A</td>
<td>Y/N</td>
<td>Y/N</td>
</tr>
<tr>
<td>6</td>
<td>Patient Ed</td>
<td>Provide Patient Ed from CEHRT</td>
<td>Unique Patients</td>
<td>&gt;10%</td>
<td>Exclusion (limited)</td>
</tr>
<tr>
<td>7</td>
<td>Med Reconcile</td>
<td>• Medication reconciliation on TOCs</td>
<td>TOCs</td>
<td>&gt;50%</td>
<td>Exclusion (limited)</td>
</tr>
<tr>
<td>8</td>
<td>Summary of Care</td>
<td>Use CEHRT to 1) create Summary of Care and 2) eTransmit to receiving provider.</td>
<td>TOCs</td>
<td>&gt;10%</td>
<td>Exclusion from eTransmit</td>
</tr>
<tr>
<td>9</td>
<td>Secure Message</td>
<td>Enable secure messaging with patient.</td>
<td>N/A</td>
<td>Y/N</td>
<td>Exclusion</td>
</tr>
<tr>
<td>10</td>
<td>Public Health</td>
<td>See next page</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Objective 10: Public Health Reporting

- EPs must meet two out of five of the public health measures each year. Exclusions are allowed for up to all five (if the criteria are met for exclusions).
- Certain Measures can only be used once to meet this Objective.

<table>
<thead>
<tr>
<th>Measure</th>
<th>Maximum Times Measure Can Count Towards Objective for EP</th>
<th>Maximum Times Measure Can Count Towards Objective for Eligible Hospital or CAH</th>
</tr>
</thead>
<tbody>
<tr>
<td>Measure 1 – Immunization Registry Reporting</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Measure 2 – Syndromic Surveillance Reporting</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Measure 3 – Case Reporting</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Measure 4 - Public Health Registry Reporting*</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Measure 5 - Clinical Data Registry Reporting**</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Measure 6 - Electronic Reportable Laboratory Results</td>
<td>N/A</td>
<td>1</td>
</tr>
</tbody>
</table>
Stage 3: Major Points: Interoperability
(Based on Provisional Rules)

- Final Stage of the Meaningful Use Program—goal is to focus on interoperability.
- All providers will be required to use Stage 3 criteria for attestation by 2018 (regardless of MU Stage).
- Allows for replacement of EHR proprietary patient portals to be replaced by less expensive “application programming interfaces,” allowing the patient to use only one “portal” for all her/his providers.
- All providers use 365-day reporting period beginning 2017 (except EPs attesting Medicaid first year use 90-day period).
- Measures aligned for EPs, hospitals and CAHs.
- Beginning CY 2017, CQM requirements included in semi-annual Inpatient Prospective Payment System (IPPS) rulemaking.
- Medicare B penalty rate adjustments remain in place.
- Expands to other health care segments (LTC, Home Care, etc.).
Stage 3 Objectives

1. Protect ePHI.
2. eRx.
4. CPOE for medication, lab, imaging.
6. Coordination of Care through Patient Engagement.
7. Transition of Care CCD.
### Stage 3: Objectives and Measures

8 Objectives: 21 Measures

<table>
<thead>
<tr>
<th>No</th>
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<th>Measures</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Protect ePHI</td>
<td>Attest “Y”</td>
<td>Continue and update annual risk assessments.</td>
</tr>
<tr>
<td>2</td>
<td>eRX</td>
<td>&gt;80% of all permissible Rx’s.</td>
<td>• Must be transmitted electronically;</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Must be queried for formulary alignment.</td>
</tr>
<tr>
<td>3</td>
<td>Clinical Decision Support</td>
<td>• Implement 5 CDS interventions;</td>
<td>• Must be in effect for entire reporting period.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Implement drug-drug and drug-allergy</td>
<td>• Relevant to EPs practice.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>interactions alerts;</td>
<td></td>
</tr>
</tbody>
</table>

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### Stage 3: Objectives and Measures - 2

**8 Objectives: 21 Measures**

<table>
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</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td>CPOE for Rx, lab, imaging.</td>
<td>• &gt;80% of Rx orders; • &gt;60% of orders for lab; • &gt;60% imaging orders.</td>
<td>eRx Must be entered by credentialed or licensed staff.</td>
</tr>
<tr>
<td>5</td>
<td>Patient eAccess within 24 hours.</td>
<td>• &gt;80% of encounters eAccess for VDT. • &gt;35% of encounters provided with relevant information (including educational).</td>
<td>VDT can take place using portal or API. Patient must be enabled on portal or API.</td>
</tr>
<tr>
<td>6</td>
<td>CEHRT Email</td>
<td>• &gt;25% of patients seen: • Transmit ePHI to a 3(^{rd}) party; OR • Use certified API for VDT.</td>
<td>Increases patient use of Portal, or the new API, from 5% in stage 1 and 2.</td>
</tr>
</tbody>
</table>
### Stage 3: Objectives and Measures -3

8 Objectives: 21 Measures

<table>
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<tr>
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<th>Measures</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>7</td>
<td>Transition of Care Record</td>
<td>• &gt;50% of all TOCs or Referrals.</td>
<td>• For TOCs/Referrals must:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• &gt;40% electronically incorporate CCD into EHR.</td>
<td>• Create CCD;</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• &gt;80% TOCs/referrals/New patients perform eReconcile on 2/3:</td>
<td>• eExchange.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Med List;</td>
<td>• Electronic incorporate into EHR.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Med Allergy;</td>
<td>• Implement eReconcile.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Problem List.</td>
<td></td>
</tr>
</tbody>
</table>
### Stage 3: Objectives and Measures - 4

#### 8 Objectives: 21 Measures

<table>
<thead>
<tr>
<th>No</th>
<th>Objective</th>
<th>Measures</th>
<th>Comments</th>
</tr>
</thead>
</table>
| 8  | Public Health or Registry Reporting | • Report to 3 out of 5 Registries:  
  • Immunization;  
  • Syndromic Surveillance;  
  • Case Reporting;  
  • Public Health Registry;  
  • Clinical Data.  
  • EPs may report to more than one PHA;  
  • EPs may report to more than one CDR. | • Since all CHC EPs are reporting to MIIS, this is a good choice to continue.  
• Registry reporting is being tested for DRVS subscribers.  
• MADPH will drive this.  
• Continue to register intent or production status each year on MADPH website. |
ONC Issuing New EHR Certification Criteria (2015 Edition) for 2017

- Reporting packages need to be revised (ASAP):
  - This includes your EHR vendor as well as any modular EHR’s (such as DRVS) you may use in addition.

- Check with your vendors about upgrade schedules—presumably, upgrades need to be scheduled for 2016 or 2017.
Thank You!

Questions??
References:

- HIMSS Summary of Stage 3: http://www.himss.org/library/meaningful-use/nprm-stage-3
- MeHI MU Toolkit: http://mehi.masstech.org/programs/medicaid-ehr-incentive-program
Your Speaker: John Cupples

- Began my health career in 1974 as the first director of Southern Jamaica Plain Health Center.
- Senior manager in hospitals and long term care including:
  - Brigham and Women’s Hospital, Vice President
  - Hebrew Senior Life, Executive, Vice President
  - Spaulding Rehabilitation Hospital Network, President
- Founded Cupples Associates Consulting, LLC. Selected clients include:
  - Partners HealthCare
  - Beth Israel Deaconess Medical Center
  - Association of Utah Community Health
  - Oklahoma Primary Care Association
  - Council of Community Clinics, San Diego
  - Boston Public Health Commission
- Massachusetts League of Community Health Centers (since 2004): Working with member CHCs to:
  - Adopt and implement EHRs
  - Achieve Meaningful Use
  - Comply with Security and Privacy Requirements
  - Strategic Planning
  - Workflow Management and Enhancement

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Our Team

Adrian Bishop
Adrian is an experienced management executive with over 16 years of consulting experience. His specialties include Health IT implementation, Change Management, Lean, UDS, Workflow design, and Strategy Alignment.

John Cupples
John has extensive healthcare management experience in community health, long term care, and hospital settings. Specialties include leadership, governance, project management, strategy, Meaningful Use, and ePHI protection.

Nancy Tabarangao
Nancy brings years of community health center management and consulting experience. Her areas of focus include planning, Meaningful Use, Workflow design, and process improvement.

Manny Molina
A former community health center CIO and director of dental informatics for a state-wide dentistry advocacy organization, Manny brings over 25 years of experience to the table. He has consulted on numerous EHR implementation projects, Meaningful Use projects, and dental implementation projects.

Emily Eagle
Trained in Informatics, Emily brings demonstrated successful experience in projects involving clinical workflow analysis, process mapping and improvement, market research, and change management. Emily has experience with HRSA UDS and has recently been developing and updating HRSA’s training materials on the UDS database. She has also participated in a number of research projects on Healthcare Reform and integration.

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