Meaningful Use Stage 1 & 2

Medicare Eligible Professionals
Introduction

This intent of this presentation is to share with you my understanding of Stage 1 and Stage 2 Meaningful Use for Medicare Eligible Professionals
### Medicare Incentives for EP’s

An EP is eligible for a 10% increase in the annual Medicare incentives if more than 50 percent of the EP’s Medicare covered professional services are furnished in a geographic health professional shortage area (HPSA).
State of ARRA & HITECH Act

- **EHR Meaningful Use**
  - Over $27B available with no cap. Protected in Medicare Trust Fund
  - Criteria well within expectations ~ 14/15 Core Measures & 5/10 Menu
  - Incentives are front-loaded so begin as soon as you can
  - As of December, over 176,000 care providers registered for Meaningful Use
  - Over $2.5 Billion in incentives paid to eligible providers & hospitals already!
    - Over $55 Million just to Nurses & PA's under Medicaid

- **EHR Certification**
  - 6 ONC-ATCB Certifying Entities
  - CCHIT remains industry gold standard

- **Regional Extension Centers**
  - Operations underway at various levels of execution
  - Engage your local REC to see how they can assist you

- **Health Information Exchanges**
  - Operations underway at various levels of operation
Agenda

- Medicare MU Eligibility Requirements
- Stage 1 Attestation and Incentive Payments
- Understanding Data Requirements
- Important Measures for ENT
- Stage 2 Proposed
Medicare Eligibility Requirements

- Eligible Professional
  - Your Physician
  - **Not PA, NP or other professionals** (Medicaid incentive only)
    - Hospital based EP does most of work inpatient or ER Dept

- Complete and accurate information for the meaningful use core and menu set measures does not have to be entered directly from information generated by certified EHR technology.
  - If EP practices at multiple locations some w/o EHR – 50% of pt visits must be at location with EHR

- Numerator, denominator, and exclusion information for CQMs must be reported directly from information generated by certified EHR technology.
CMS Registration for Attestation

- Registration for the Medicare EHR Incentive Program is available online at
  https://ehrincentives.cms.gov/

- In order to receive Medicare EHR incentive payments, EPs must have an enrollment record in PECOS.

- Check the Ordering Referring Report on the CMS website. If you are on that report, you have a current enrollment record in PECOS. Go to http://www.cms.gov/MedicareProviderSupEnroll/, click on "Ordering Referring Report" on the left.
Registration
- Register in the Incentive Payment Program
- Continue Incomplete Registration
- Modify Existing Registration
- Resubmit a Registration that was previously deemed ineligible
- Reactivate a Registration
- Switch Incentive Programs (Medicare/Medicaid)
- Switch Medicaid State
- Cancel participation in the Incentive Program

Attestation
Medicare
- Attest for the Incentive Program
- Continue Incomplete Attestation
- Modify Existing Attestation
- Discontinue Attestation
- Resubmit Failed or Rejected Attestation
- Reactivate Canceled Attestation

Note: Attestation for the Medicaid incentive program occurs at the State Medicaid Agency.

Status
- View current status of your Registration, Attestation, and Payment(s) for the
Attestation on Behalf of

Users registering or attesting on behalf of an EP must have their own Identity and Access Management System (I&A) web user account and be associated to the EP's NPI. If you are working on behalf of an EP(s) and do not have an I&A web user account must create one by visiting:

https://nppes.cms.hhs.gov/NPPES/IASecurityCheck.do
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<td>Steven David Shotts</td>
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<td>Andrew Richard Gould</td>
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<td>Wes Ashley Allison</td>
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</tbody>
</table>
Attestation continued…

- You will need Certification number of your EHR. You can perform a search for EHR Certification numbers on the CMS attestation website.
  - 30000001SVGGEAC (Greenway)

- The reporting period for initial bonus Stage 1 for 2012 - is 90 continuous days within the calendar year
Stage 1 Attestation 2011 vs 2012

Eligible professionals may report core and menu quality measures for meaningful use via attestation in 2012, just as they did in 2011

– option to report CQM data electronically to CMS via health information network (State, CMS or registry)
Clinical Quality Measures

eReporting
Are you planning to participate in the Physician Quality Reporting System-Medicare EHR Incentive Pilot for 2012?

☐ Yes  ☐ No

If you selected yes, you will need to electronically submit your clinical quality measures and you will NOT be able to attest CQM results. The reporting period for CQMs submitted electronically will be the **entire 2012 Calendar Year**. Please continue to submit your attestation in the Registration and Attestation System once you have completed the Meaningful Use Core and Meaningful Use Menu measures.

If you selected no, then you will be allowed to attest to the CQMs and you may also submit your CQMs electronically. To note, you will be paid based on your attestation and not be placed in a pending pilot status.

Please reference the [Clinical Quality Measure Specification Page](#) for more information on CQM eReporting.

Please select the **Previous** button to go back a page. Select the **Return to Attestation Progress** button to view your progress through the attestation topics. Please note that any changes that you have made on this page will not be saved. Select the **Save & Continue** button to save your entry and proceed.
Important 2012 Dates

- October 3, 2012 – Last day for eligible professionals to begin their 90-day reporting period for calendar year 2012 for the Medicare EHR Incentive Program.
- December 31, 2012 – Reporting year ends for eligible professionals to qualify for full $44,000
- February 29, 2013 – Last day for eligible professionals to register and attest to receive an Incentive Payment for calendar year (CY) 2012.
- To stop the 2015 pay adjustment from taking effect, a physician must achieve meaningful use objectives in the 2013 reporting year or by Oct. 1 of the 2014 reporting year.
Meaningful Use Incentive
Requirements for MU Incentive

- 20 of 25 objectives must be met, including:
  - 15 required core objectives
  - 5 menu set objectives that may be chosen from a list of 10

- Report clinical quality measures
  - 3 required core measures (substituting alternate core measures where necessary) and…
  - 3 additional measures (selected from a set of 38 clinical quality measures)
Incentive Payment

- Incentive payments for the Medicare EHR Incentive Program will be made approximately four to eight weeks after an EP successfully attests.

*I attested 1/25/2012 and received payment 3/23/2012 = 8 weeks + 2 days*

- Payments will be made to the taxpayer identification number (TIN) selected at the time of registration. The form of payment (electronic funds transfer or check) will be through the same channels as claims payments.
Payment Based on Claims Data

If the EP has not met the $24,000 threshold in allowed charges by the end of calendar year 2012 - CMS will issue an incentive payment for the EP based on actual allowed charges. This will occur in March 2013 (allowing 60 days after the end of the 2012 calendar year for all pending claims to be processed).
Understanding Data Requirements

Tips and Tricks
The Patient Visit

- **Some measures are for unique visits vs. all visits**
  - **Unique Patient** – If a patient is seen by an EP more than once during the EHR reporting period, then for purposes of measurement that patient is only counted once in the denominator for the measure.

- **Patient must SEE the EP**
  - the Patient & EP have an actual physical encounter in which the EP renders any service to the patient (includes telemedicine)
  - **Do not include visits where the patient does not see the EP ie: allergy injections, nurse visits**
  - Make sure you learn how your EHR excludes non EP visits from the Clinical Quality Measure denominator
The Measures

Core (CO) and Menu Set Objectives (MO) Defined

15 Meaningful Use Core Measures

1. CPOE for Medication Orders
2. Drug-Drug & Drug-Allergy Checks
3. Problem List
4. E-Prescribe
5. Medication List
6. Medication Allergy List
7. Record Demographics
8. Vital Signs
9. Smoking Status
10. Report Clinical Quality Measures
11. Clinical Decision Support
12. Electronic Copy of Health Information
13. Clinical Summaries
14. Exchange Key Clinical Information
15. Privacy & Security Risk Assessment
CO Measures you should meet—“How to” will be EHR specific

✓ CO1 Computerized Provider Order Entry
  Medications ordered by Physician
✓ CO2 Drug-Drug and Drug/Allergy checks
  Attest Yes
✓ CO3 Problem List and Diagnosis
  (requires new steps for your clinical team – watch this closely)
✓ CO5 Active Medication List
✓ CO6 Active Medication Allergy List
✓ CO7 Record Demographics
✓ CO9 Smoking Status
CO4  e-Prescribe
>40% of Permissible Prescriptions

Any drug requiring a prescription in order to be dispensed, other than controlled substances must be generated and transmitted electronically and this results in the prescription being filled without the need for the provider to communicate the prescription in an alternative manner.

*Monitor this measure daily/weekly*
CO4  e-Prescribe

If you Dispense Drugs:

- For purposes of counting prescriptions "generated and transmitted electronically," we consider the generation and transmission of prescriptions to occur constructively if the prescriber and dispenser are the same person and/or are accessing the same record in an integrated EHR to creating an order in a system that is electronically transmitted to an internal pharmacy.
EHR and ERX Medicare Incentive

FYI:

EPs cannot receive incentive payments for e-prescribing under both the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) and the Medicare EHR Incentive Program for the same year.
CO7 – Record Demographics

**Objective** – Record all of the following demographics

- Sex
- Date of Birth
- Race
- Ethnicity*
- Primary Language*

*TIP: *add “declined” as an option on your demographic form

**Measure** - More than 50% of all unique patients seen by the EP have all 5 of these elements of demographic data.
The only information required to be inputted by the provider is the height, weight, and blood pressure of the patient. The certified EHR technology will calculate BMI and the growth chart if applicable to patient based on age.
CO8  Vital Signs Exclusion

An exclusion for this objective is provided only for EPs who either see no patients 2 years or older, or who believe that **all three** vital signs of **height, weight, and blood pressure** of their patients **have no relevance to their scope of practice**.

If an EP believes that **one or two** of these vital signs are **relevant** to their scope of practice, (they routinely obtain 1-2 vital signs) then they **must record all three** vital signs in order to meet the measure of this objective and successfully demonstrate meaningful use.

*Monitor this measure closely*
CO9 – Smoking Status

Objective – Record smoking status for patients 13 years old or older.

Measure - More than 50% of all unique patients 13 years old or older seen by the EP have smoking status recorded as structured data.

Tip/Exclusions – If an EP does not see any patients 13 years or older, he/she can exclude themselves from this measure.

*Your EHR may have a new field you will need to add*
Attesting to the measure of this objective indicates that the EP will submit complete clinical quality measure information as required. EPs will also attest to the numerators, denominators, and exclusions for individual clinical quality measures.

You will attest “Yes”
CO11  Clinical Decision Support
  Attest         Yes/No

Implement one clinical decision support rule relevant to specialty or high clinical priority along with the ability to track compliance with that rule ie: pts with dx of cancer who have not had a chest x-ray ordered in 12 mos

*Must be performed once per EP and have results of report available if audited*
CO12  Electronic Copy of Record

>50% of pts who request it

- The media can be any electronic form such as patient portal, PHR, CD, USB. EPs are expected to make reasonable accommodations for patient preference as outlined in 45 CFR 164.522(b).
- You can charge a reasonable cost based fee
- It is all health information you have on the patient
- Do not have to supply electronic copy to 3rd party requests from lawyers/insurance
- Cut off date for requests is 4 days prior to end of your 90 day reporting period
An EP who has no requests from patients or their agents for an electronic copy of patient health information during the EHR reporting period would be excluded from this requirement.
CO 13  Clinical Summary

>50% of all E&M patient visits

- Must document in EHR that a clinical summary was provided *within 72 hours of visit*
- Print it, USB fob, send it secure email, pt. portal
  - Cannot charge the patient for this information
- Clinical summary must contain at a minimum
  - Problem List
  - Diagnostic Test Results
  - Medication List
  - Medication Allergy List

*Monitor this measure daily/weekly*
Exchange is defined as electronic transmission and acceptance of key clinical information by any means of electronic transmission (not fax).

- Use a “Dummy” Patient
- If the test involves the transmission of actual patient information, all current privacy and security regulations must be met.
Exchange continued..

Exchange information with

✓ different legal entities
✓ with certified EHR technology (can be same vendor)
❌ not between organizations that share a certified EHR technology
❌ not between organizations that are part of the same legal entity,
Meaningful Use Menu Set Objectives (Choose 5)

1. Drug-Formulary Checks
2. Incorporate clinical lab-test results into EHR as structured data
3. Patient List
4. Patient Reminders per patient preference
5. Timely Electronic Access (within 4 business days of being available to EP)
6. Patient Education
7. Medical Reconciliation
8. Summary of Care
9. Capability to submit electronic data to immunization registries
10. Capability to submit electronic syndromic surveillance data to public health agencies
Attest YES to having enabled drug-drug and drug-allergy interaction checks for the length of the reporting period to meet this measure.
MO2  Clinical Lab Test Results

>40% of labs ordered by EP

The denominator consists of the number of lab tests ordered whose results are expressed in a positive or negative affirmation or as a number.

- You can limit the denominator to only those lab tests that were ordered during the reporting period and for which results were received during the reporting period.

- The EP may count in the numerator all structured data entered through manual entry through typing, option selecting, scanning, or other means.
MO3 Patient Lists

Attest Yes/No

You must generate at least one report listing patients of the EP with a specific condition to meet this measure ie: all patients on beta blockers

Must generate one report per EP

- This objective does not dictate the condition for which you are to generate a report
MO4 – Patient Reminder

Objective – Send reminders to patients per patient preference for preventative/follow-up care.

Measure - More than 20% of all unique patients 65 years or older or 5 years or younger were sent an appropriate reminder during the EHR reporting period.

Typically your EHR will create an alert to auto generate Recalls and typically you will need to complete “patient’s preferred communication” field in EHR
MO5 – Timely Electronic Access

**Objective** – Provide patients with timely electronic access to their health information within four business days of the information being available to the EP.

**Measure** - More than 10% of all unique patients seen by the EP are provided timely electronic access to their health information *subject to the EP’s discretion to withhold certain information.*

This is essentially the same as CO14, the difference being the 4 days given to send the information.
MO6  Patient Education Materials

> than 10% of “unique” patients

The patient-specific education resources or materials do not have to be stored within or generated by the certified EHR.

Your EHR technology should suggest patient-specific educational resources based on the information stored in the certified EHR technology (ie: based on pt’s diagnosis)
M07    Medication Reconciliation
>50% of transitions of care

- Process of identifying the most accurate list of medications by comparing medical record to an external list from patient, hospital or other provider
- Transition of care is when the EP receives the patient from another setting of care or provider
- Or EP feels encounter is relevant
MO8 Summary/Transition of Care

>50% of transitions of care

EP transfers patient to another setting of care or provider must provide summary of care record

To satisfy "provide a summary of care record for each transition of care" a provider is permitted to send an electronic (CD, USB) or paper copy of the summary care record directly to the provider or can provide it to the patient to deliver.

If the provider to whom the patient is transitioned has access to the medical record maintained by the referring provider then the summary of care record would not need to be provided, and that patient should not be included in the denominator for transitions of care.
Objective – Capability to submit electronic data to immunization registries or Immunization Information Systems and actual submission in accordance with applicable law and practice.

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

State officials responsible for the administration of the immunization registry have determined to use KHIE as the sole option for electronic submission of immunization records

http://KHIE.Ky.Gov
MO10 – Syndromic Surveillance

Objective – Capability to submit electronic syndromic surveillance to public health agencies and actual submission in accordance with applicable law and practice.

Measure - Perform at least one test of EHR’s capacity to submit electronic syndromic surveillance data to public health agencies and follow up submission to see if the test is successful.

If for any reason (e.g. waiting list, on-boarding process, other requirements, etc) the registry cannot test with a specific EP or hospital, that EP can exclude the objective.
Clinical Quality Measures (CQM)

You will report a minimum of six CQM measures

- 3 CORE CQM
- *ALTERNATE Core CQM
- 3 ADDITIONAL CQM
Clinical Quality Measures (CQM)

- Please note that quality performance results for CQMs are not being assessed at this time under the EHR Incentive Programs.
- There are no thresholds that must be met - you simply report your numerator/denominator for each CQM.
CQM Zero Denominator

If the denominator value for all three of the core clinical quality measures is zero, an EP must report a zero denominator for all such core measures, and then must also report on all 3 alternate core clinical quality measures. If the denominator values for all three of the alternate core clinical quality measures is also '0,' an EP still needs to report on 3 additional clinical quality measures.

Zero is an acceptable denominator provided that this value was produced by certified EHR technology.
## Meaningful Use Dashboard

### Privacy & Security
- **Status**: Yes
- **Requirement Met:** Yes

### Quality Measures

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<th>Measure Name</th>
<th>Statistics</th>
<th>Requirement Status</th>
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<td>NQF 0421 - Adult Weight Screen/Follow-up - N1D1</td>
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<td>NQF 0013 - Hypertension: BP Mgmt</td>
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<tr>
<td></td>
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<tr>
<td>NQF 0028b - Tobacco Cessation Intervention</td>
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<td>Current%: 0%</td>
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<td></td>
<td></td>
<td>Exclusions: 0</td>
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<tr>
<td>NQF 0041 - Influenza Immunization for Patients &gt;= 50 Years Old</td>
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<td>Current%: 0%</td>
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<td></td>
<td></td>
<td>Exclusions: 0</td>
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<tr>
<td>NQF 0024 - Weight Assessment/counsel for Child &amp; Adolescents - N1D1</td>
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<td></td>
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</tbody>
</table>
CORE CQM

Must try to meet all 3 of the Core CQM

1. NQF 0013 Hypertension
2. NQF 0421 Adult Weight Screen and Follow up
3. NQF 0028a Tobacco Use Assessment
   NQF 0028b Tobacco Cessation Intervention
NQF 0013 Hypertension

≥ 18 y/o with active diagnosis of hypertension seen for two office visits with B/P recorded

- ICD9 401.0-404.93
- Record B/P in EHR
NQF 0421 Adult Weight Screen and Follow up

- Patients 18 or older with BMI outside normal limits with documented follow up plan
  - Normal Parameters: Age 65 and older BMI ≥23 and <30
    Age 18 – 64 BMI ≥18.5 and <25

- Follow-up Plan – Proposed outline of treatment to be conducted as a result of abnormal BMI measurement. Such follow-up can include documentation of a future appointment, education referral -such as, a registered dietician, nutritionist, primary care physician
  - **ADD CPT G8417:** Calculated BMI above the upper parameter and a follow-up plan was documented in the medical record (referral to dietician or FP)
  - **ICD-9- V65.3** Dietary surveillance and counseling
NQF 0028a Tobacco Use Assessment

Must query patients $\geq 18$ yrs of age who have been seen at least twice in last 24 months about their tobacco use

You are already doing this with CO9 “Smoking Status”
NQF 0028b Tobacco Cessation Intervention

Patients $\geq 18$ yrs of age who have been seen at least twice and identified as tobacco user within the last 24 months

- Provide cessation counseling and document with code 99406 or 99407 (counseling “x” minutes)
- Or provide cessation treatment and document by prescribing a medication ie: Chantix
Alternate Core Clinical Quality Measures

If you have a “zero” denominator for a Core CQM then you must choose from one of the three Alternate Core CQMs
Alternate Clinical Quality Measures

- NQF 0024 Weight Assessment and Counseling for Children and Adolescents
- NQF 0041 Influenza Immunization for Patients 50 years old or older
- NQF 0038 Childhood Immunization Status
Additional Clinical Quality Measures

In addition to the three Core Measures you must complete THREE Additional Clinical Quality Measures
NQF 0027 Smoking & Tobacco Use Cessation

Patients 18 or older who are current tobacco users, seen by EP who were advised to quit or recommended or discussed cessation medications, strategies

Provide counseling or recommend or prescribe appropriate medication

- Add CPT code 99406 – tobacco counseling 3-10min
- Add Dx code V70.9 – unspecified general medical exam
NQF 0002 Testing Children with Pharyngitis

Children 2-18 yrs diagnosed with pharyngitis, dispensed an AB and received a STREP test

- CPT 87880 (streptococcus group A)
- Order Antibiotic if strep positive
NQF 0001 Asthma Assessment

Patients age 5-40 yrs with a diagnosis of asthma who have been seen for 2 visits and were evaluated within last 12 months for frequency (numeric) of daytime and nocturnal asthma symptoms
NQF 0018 Controlling High B/P

The percentage of patients 18-85 years of age who had a diagnosis of hypertension and whose B/P was adequately controlled during the measurement year.
After STAGE 1 attestation in 2011 or 2012

- Until Stage 2 requirements become final you will continue to report MU data using Stage 1 criteria HOWEVER you must report for a full 12 months
- Participation in e-reporting CQM reporting for 2012 is voluntary – may be required in 2013 for Stage 1
Core Clinical Quality Measures

New in 2012
Potential Changes for Stage 1 in 2013

- The rule proposes a change in the objective of ‘record and chart changes in vital signs’ that an EP should be allowed to split the exclusion and exclude blood pressure only or height/weight only. It is proposed for Stage 1 starting in CY 2013 and Stage 2 of meaningful use.

- Changes to age limitations on vital signs have also been proposed for Stage 1 starting in CY 2013

- Electronic CQM reporting becomes required for Stage 2
Meaningful Use Stage 2

- Criteria Finalized in mid-2012
- Reporting Period Begins 2014 for Stage 2
- Stage One Menu Objectives Become Core Items
- Patient Volume & Percentage Threshold Increases
  - Electronic Prescribing ~ Increases to 60% of prescriptions
  - Record Vital Signs ~ Increases to 80% of patients
- Clinical Quality Measures Calculated Electronically
- Summary of Care will be Expanded to Include Care Plan and Patient Instructions
STAGE 2 Meaningful Use

- The proposed stage 2 rule is expected to be finalized in summer 2012
- Stage 2 will begin in 2014 for those who receive their first bonuses in 2011 or 2012
- EMR bonuses would be more difficult to achieve during the second stage of the program
- It’s all about intraoperability and patient engagement
# STAGE 2 MEANINGFUL USE

<table>
<thead>
<tr>
<th>Measures</th>
<th>Stage 1</th>
<th>Stage 2</th>
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<tr>
<td>Core set</td>
<td>Report all 15</td>
<td>Report all 17</td>
</tr>
<tr>
<td>Menu set</td>
<td>Report 5 of 10</td>
<td>Report 3 of 5</td>
</tr>
<tr>
<td>CQM</td>
<td>Report ≥ 6</td>
<td>Report ≥ 12</td>
</tr>
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</table>
Five (not 10) Menu Objectives

(must select and meet three)

1. More than 40% of all imaging results and information are accessible through certified EHR technology
2. Patient family health history is recorded for more than 20% of unique patients
3. Send electronic syndromic surveillance data to public health agencies
4. Have ability to report cancer cases to state registries
5. Have ability to report noncancer cases to state registries
Significant Changes to Core Measures for Stage 2 = Intraoperability

- Patients are provided online access to their health information (via a web portal) on 50% of the occasions, and further, 10% unique patients actually view, download or transmit that data to a third party.

- Secure electronic messaging is utilized to communicate with patients on relevant health information for 10% of unique patients.

- Elimination of the "exchange of key clinical information" in favor of a "transitions of care” core objective that requires electronic exchange of summary of care documents.
Stage 3 Meeting Desired Outcomes

- **Stage 3 will maintain Stage 2 Criteria**
  - Further increases patient volume and other thresholds in some areas, beginning 2015 or later

- **Will enhance bi-directional data exchange with public health agencies utilizing existing criteria**
  - Immunization data to registries
  - Lab data to registries
  - Syndromic surveillance to public health registries

- **Demonstrate improvement in patient outcomes**
  - Provide patients access to self-management tools
  - Allow patients to upload generated data
  - Example ~ Reduce major drug interactions & readmission rates
Any Questions

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