Welcome

Moving Forward with Meaningful Use in the HCH Setting

Thursday, November 8, 2012

We will begin promptly at 1 p.m. Eastern.

Event Moderator:

Melissa DaSilva, MS, RN
Deputy Director
National Health Care for the Homeless Council

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Moving Forward with Meaningful Use in the HCH Setting

November 8, 2012

Event Host:
Anna Gard, MSN FNP-BC
Health Disparities Consultant
Association of Clinicians for the Underserved
Presenters

Robert Anthony
Health Specialist
Office of E-Health Standards & Services
Centers for Medicare & Medicaid Services

Lance Luttrell
Administrator of Oral Health Services
Christ Community Health Services
What is in the Rule

- Changes to Stage 1 of meaningful use
- Stage 2 of meaningful use
- New clinical quality measures
- New clinical quality measure reporting mechanisms
- Payment adjustments and hardships
- Medicaid program changes
Stage 2 Eligibility
Stage 2 Change: Hospital-Based EP Definition

EPs can demonstrate that they fund the acquisition, implementation, and maintenance of CEHRT, including supporting hardware and interfaces needed for meaningful use without reimbursement from an eligible hospital or CAH — in lieu of using the hospital’s CEHRT — can be determined non-hospital-based and potentially receive an incentive payment.

Determination will be made through an application process.
Stage 2 Meaningful Use
What is Your Meaningful Use Path?

For Medicare EPs:

<table>
<thead>
<tr>
<th>Maximum Payment by Start Year</th>
<th>Annual Incentive Payment by Stage of Meaningful Use</th>
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</thead>
<tbody>
<tr>
<td>2011</td>
<td>1</td>
</tr>
<tr>
<td>$44,000</td>
<td>$18,000</td>
</tr>
<tr>
<td>2012</td>
<td>1</td>
</tr>
<tr>
<td>$44,000</td>
<td>$18,000</td>
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<td>2013</td>
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<td>$39,000</td>
<td>$15,000</td>
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<tr>
<td>2014</td>
<td>1</td>
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<tr>
<td>$24,000</td>
<td>$12,000</td>
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</table>
2014 Changes

1. **EHRs Meeting ONC 2014 Standards** – starting in 2014, all EHR Incentive Programs participants will have to adopt certified EHR technology that meets ONC’s Standards & Certification Criteria 2014 Final Rule.

2. **Reporting Period Reduced to Three Months** – to allow providers time to adopt 2014 certified EHR technology and prepare for Stage 2, all participants will have a three-month reporting period in 2014.
Changes to Meaningful Use

**Changes**

- **Menu Objective Exclusion**—While you can continue to claim exclusions if applicable for menu objectives, starting in 2014 these exclusions will no longer count towards the number of menu objectives needed.

**No Changes**

- **Half of Outpatient Encounters**—at least 50% of EP outpatient encounters must occur at locations equipped with certified EHR technology.

- **Measure compliance = objective compliance**

- **Denominators based on outpatient locations equipped with CEHRT** and include all such encounters or only those for patients whose records are in CEHRT depending on the measure.
Stage 2: Batch Reporting

Stage 2 rule allows for batch reporting.

What does that mean?

Starting in 2014, groups will be allowed to submit attestation information for all of their individual EPs in one file for upload to the Attestation System, rather than having each EP individually enter data.
Meaningful Use: Changes from Stage 1 to Stage 2

**Stage 1**

**Eligible Professionals**
- 15 core objectives
- 5 of 10 menu objectives
- 20 total objectives

**Eligible Hospitals & CAHs**
- 14 core objectives
- 5 of 10 menu objectives
- 19 total objectives

**Stage 2**

**Eligible Professionals**
- 17 core objectives
- 3 of 6 menu objectives
- 20 total objectives

**Eligible Hospitals & CAHs**
- 16 core objectives
- 3 of 6 menu objectives
- 19 total objectives
Closer Look at Stage 2: Patient Engagement

- **Patient engagement** – engagement is an important focus of Stage 2.

**Requirements for Patient Action:**
- *More than 5% of patients* must send secure messages to their EP
- *More than 5% of patients* must access their health information online

- **EXCLUSIONS** – CMS is introducing exclusions based on broadband availability in the provider’s county.
Closer Look at Stage 2: Electronic Exchange

Stage 2 focuses on actual use cases of electronic information exchange:

- Stage 2 requires that a provider send a summary of care record for more than 50% of transitions of care and referrals.

- The rule also requires that a provider electronically transmit a summary of care for more than 10% of transitions of care and referrals.

- At least one summary of care document sent electronically to recipient with different EHR vendor or to CMS test EHR.
Clinical Quality Measures
Aligning CQMs Across Programs

• CMS’s commitment to alignment includes finalizing the same CQMs used in multiple quality reporting programs for reporting beginning in 2014
• Other programs include Hospital IQR Program, PQRS, CHIPRA, and Medicare SSP and Pioneer ACOs
Electronic Submission of CQMs
Beginning in 2014

• Beginning in 2014, all Medicare-eligible providers in their second year and beyond of demonstrating meaningful use **must electronically report** their CQM data to CMS.

• Medicaid providers will report their CQM data to their state, which may include electronic reporting.
Payment Adjustments & Hardship Exceptions

Medicare Only
EPs, Subsection (d) Hospitals and CAHs
Payment Adjustments

- The HITECH Act stipulates that for Medicare EP, subsection (d) hospitals and CAHs a payment adjustment applies if they are not a meaningful EHR user.
- An EP, subsection (d) hospital or CAH becomes a meaningful EHR user when they successfully attest to meaningful use under either the Medicare or Medicaid EHR Incentive Program.

Adopt, implement and upgrade ≠ meaningful use

A provider receiving a Medicaid incentive for AIU would still be subject to the Medicare payment adjustment.
EP EHR Reporting Period

Payment adjustments are based on prior years’ reporting periods. The length of the reporting period depends upon the first year of participation.

For an EP who has demonstrated meaningful use in **2011** or **2012**:

<table>
<thead>
<tr>
<th>Payment Adjustment Year</th>
<th>2015</th>
<th>2016</th>
<th>2017</th>
<th>2018</th>
<th>2019</th>
<th>2020</th>
</tr>
</thead>
<tbody>
<tr>
<td>Based on Full Year EHR Reporting Period</td>
<td>2013</td>
<td>2014*</td>
<td>2015</td>
<td>2016</td>
<td>2017</td>
<td>2018</td>
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* Special 3 month EHR reporting period

**To Avoid Payment Adjustments:**
EPs **must** continue to demonstrate meaningful use every year to avoid payment adjustments in subsequent years.
EP EHR Reporting Period

For an EP who demonstrates meaningful use in 2013 for the first time:

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<th>2015</th>
<th>2016</th>
<th>2017</th>
<th>2018</th>
<th>2019</th>
<th>2020</th>
</tr>
</thead>
<tbody>
<tr>
<td>Based on 90 day EHR Reporting Period</td>
<td>2013</td>
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<tr>
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<td></td>
<td>2015</td>
<td>2016</td>
<td>2017</td>
<td>2018</td>
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*In order to avoid the 2015 payment adjustment the EP must attest no later than October 1, 2014, which means they must begin their 90 day EHR reporting period no later than July 1, 2014.
# Hardship Exceptions

<p>| | |</p>
<table>
<thead>
<tr>
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</tr>
</thead>
<tbody>
<tr>
<td><strong>Infrastructure</strong></td>
<td><strong>New Providers</strong></td>
</tr>
<tr>
<td>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).</td>
<td>Newly practicing EPs who would not have had time to become meaningful users can apply for a 2-year limited exception to payment adjustments. (Hospitals can apply for a 1-year limited exception.)</td>
</tr>
<tr>
<td><strong>Unforeseen Circumstances</strong></td>
<td><strong>EPs must demonstrate that they meet the following criteria:</strong></td>
</tr>
</tbody>
</table>
| Examples may include a natural disaster or other unforeseeable barrier. | • Lack of face-to-face or telemedicine interaction with patients  
• Lack of follow-up need with patients |
| **EPs who practice at multiple locations must demonstrate that they:** | **EPs who practice at multiple locations must demonstrate that they:** |
| • Lack of control over availability of CEHRT for more than 50% of patient encounters |
EP Hardship Exceptions

EPs whose primary specialties are anesthesiology, radiology or pathology:

As of July 1\textsuperscript{st} of the year preceding the payment adjustment year, EPs in these specialties will \textit{automatically} receive a hardship exception based on the 4\textsuperscript{th} criteria for EPs

**EPs must demonstrate that they meet the following criteria:**
- Lack of face-to-face or telemedicine interaction with patients
- Lack of follow-up need with patients
Medicaid-Specific Changes
Medicaid Eligibility Expansion

Patient Encounters:
The definition of what constitutes a Medicaid patient encounter has changed. The rule includes encounters for anyone enrolled in a Medicaid program, including Medicaid expansion encounters (except stand-alone Title 21), and those with zero-pay claims.

- The rule adds flexibility in the look-back period for overall patient volume.
Stage 2 Resources

CMS Stage 2 Webpage:


Links to the Federal Register

- CMS Rule:
  http://www.ofr.gov/(X(1)S(uzclbwrxdqm2w2mipkysrh))/OFRUpload/OFRData/2012-21050_PI.pdf
- ONC Rule:
  http://www.ofr.gov/(X(1)S(uzclbwrxdqm2w2mipkysrh))/OFRUpload/OFRData/2012-20982_PI.pdf

Tipsheets

- Stage 2 Overview
- 2014 Clinical Quality Measures
- Payment Adjustments & Hardship Exceptions (EPs & Hospitals)
- Stage 1 Changes
- Stage 1 vs. Stage 2 Tables (EPs & Hospitals)
Implementing a Meaningful Journey

Lance Luttrell
Administrator of Oral Health Services
Why?
Hippocratic Oath

- Do no harm
- Freely share information (and hard earned insights) with colleagues
- Prevention is greater than a cure
- Navigate between overtreatment and neglect
Why?

NATIONAL HEALTH CARE for the HOMELESS COUNCIL
NHCHC

- Advocacy for the improvement of health care systems
- Research of critical issues
- Organize health care providers to provide better care for the homeless
Why?

NATIONAL HEALTH CARE for the HOMELESS COUNCIL

Christ Community HEALTH SERVICES
CCHS Mission

“...provide high quality health care in the context of distinctively Christian service...”

• High Quality
• Serving Jesus means serving the homeless
• Christian service compels us to comply with government regulations
How are you implementing an EHR?

Continually walking the narrow path between:

• User friendly to providers and Helpful practice management

• Costly Abstraction vs. Cutting Access to Information

• Mimicking paper work flows vs. Adjusting for Meaningful Use
Integrated EMR and PM

e-MDs
CHARTING THE FUTURE OF HEALTHCARE®
Reduced Productivity

Average of Total Goal Per

Location
- Broad
- Frayser
- Hickory Hill
- Mobile
- Orange Mound
- Third Street

Month Name
Making the Transition

• Training at our administration site for 2 days
• 2 Days of on-site training and support
• Identifying and support a super-user for each clinic – clerical, nursing, and provider
• Fake patient walk-throughs
• Engaging the entire clinical staff for the EMR transition and to achieve MU
What We Have Done

• Worked to educate and inform providers about Meaningful Use requirements
• Used and created reports to establish provider accountability to MU requirements
• Worked with QSource / TnREC to find workarounds for things that adjust our workflow
## Quick Guide

<table>
<thead>
<tr>
<th>Core 1 - CPOE</th>
<th>Core 2 - Drug-Drug and Drug-Allergy Checks</th>
<th>Core 3 - Problem List</th>
<th>Core 4 - ePrescribing</th>
<th>Core 5 - Medication List</th>
</tr>
</thead>
<tbody>
<tr>
<td>Numerator - Patients with at least 1 medication in med list Denominator - Patients with qualifying E&amp;M Codes</td>
<td>Goal = 30% Attestation Only</td>
<td>Goal = 80% Numerator - at least 1 entry or NCP Denominator - Qualifying E&amp;M code</td>
<td>Goal = 40% Numerator - transmitted electronically Denominator - Non-custom, non-Schedule II-V drugs</td>
<td>Goal = 80% Numerator - at least 1 entry or NKM Denominator - Qualifying E&amp;M code</td>
</tr>
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</table>

**Similar to:**

http://www.chitrec.org/sites/default/files/Step1MUCriteria_EP.pdf
# Meaningful Accountability

All of the criteria listed below are the ones chosen by COHS and need to be met by all COHS providers over the Reporting Period. A legend for the criteria is listed below:

- **C1**: CPOE (30%)
- **C3**: Problem List (30%)
- **C5**: ePrescribing (20%)
- **C7**: Allergy List (30%)
- **C9**: Medication List (80%)
- **C12**: Health Info on Request (50%)
- **C13**: Vist Summaries (50%)
- **C14**: Lab as Structure Data (80%)
- **M2**: Patient Education (10%)
- **M3**: CCD on Transition of Care
- **M4**: Clinical Reminders

<table>
<thead>
<tr>
<th></th>
<th>C1</th>
<th>C3</th>
<th>C4</th>
<th>C5</th>
<th>C6</th>
<th>C7</th>
<th>C8</th>
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<td>90%</td>
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<td>91%</td>
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<td>N/A</td>
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<td>3%</td>
<td>97%</td>
<td>N/A</td>
<td>90%</td>
</tr>
</tbody>
</table>
Menu Set Selection

- Guide: make Meaningful Use how the providers already use the system.
  - Menu Set 2: Lab as Structured Data (LabCorp/Quest)
  - Menu Set 3: Generate Patient List (done centrally)
  - **Menu Set 4: Clinical Reminders (done centrally)**
  - **Menu Set 6: Patient Education**
  - Menu Set 8: CCD on Transition of Care (front desk)
  - Menu Set 9: Immunization Data to State Registry
Adjustments to Work Flow

• Visit Summaries
  – Requires providers to be reasonably finished with their note at time of patient departure
  – 50% leads us to doing it for almost every patient
  – Feels like a waste of paper to providers
  – Provides a medication list and list of diagnoses

• Patient Education
  – Fits our model, but requires specific documentation
Adjustments to Work Flow

• Problem List Maintenance for pediatric patients who come in for a sick visit
• E-Prescribing a unique problem to Mobile Van
  – Distribute many samples of drugs
  – Decreased the number of electronically submitted
  – Found a way to document samples instead of paper prescriptions
Why?
Lance Luttrell
Administrator of Oral Health Services
lance.luttrell@christchs.org
Q & A

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Centers for Medicare & Medicaid Services

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Christ Community Health Services

Health Care and Housing are Human Rights
Resources

- National Health Care for the Homeless Council [www.nhchc.org](http://www.nhchc.org)
- American Academy of Family Physicians Center for Health Information Technology [http://www.centerforhit.org](http://www.centerforhit.org)
- Patient Centered Primary Care Collaborative Meaningful Connections Guide [http://www.pcpcc.net/content/health-information-exchangehit](http://www.pcpcc.net/content/health-information-exchangehit)
- Safety Net Medical Home Initiative [http://www.qhmedicalhome.org/safety-net/about.cfm](http://www.qhmedicalhome.org/safety-net/about.cfm)
- eHealth Initiative Connecting Communities [http://www.toolkit.ehealthinitiative.org](http://www.toolkit.ehealthinitiative.org)
- HITSP (Health Information Technology Standards Panel) [http://www.hitsp.org](http://www.hitsp.org)
- HRSA Safety Net Health IT webinars [http://www.hrsa.gov/healthIT](http://www.hrsa.gov/healthIT)
Thank you for your participation.

For more information on PCMH and MU, be sure to check the Council website at https://www.nhchc.org/resources/general-information/health-care-reform/.

Also, look for more information soon on the National Health Care for the Homeless National Conference March 14-16, 2013, in Washington, D.C.