2015-2017 Meaningful Use FINAL Rule

Cathy Costello, JD
Director of CliniSync PLUS Services

Scott Mash, MSLIT, CPHIMS, FHIMSS
Director of Consulting Operations & HIE Outreach
THIS PRESENTATION ONLY COVERS 2015-2017 MEANINGFUL USE

WE WILL CONDUCT A SEPARATE WEBINAR IN 2 WEEKS THAT WILL COVER STAGE 3 PROPOSALS
MU Rules Released 10-6-15

The policy rule released on Tuesday, October 6, 2015 covers:

- 2015 and 2016 MU reporting
- 2017 transitional reporting for Stage 3
- 2018 Stage 3, as proposed

The certification criteria rule was released simultaneously; criteria cover the Stage 3 upgrades. This version is referred to as “2015 Edition” CEHRT.
Timeline for MU Rules

- The MU measures for 2015 and 2016 are final effective 60 days after publication.

- The policy rules for 2015 – 2017 MU and Stage 3—RIN 0938-AS58 (2015-2017) and RIN 0938-AS26 (Stage 3)—have been combined and will be formally published in the Federal Register October 16, 2015.

- The policy rule will become final effective December 15, 2015.

- The related rule, the certification criteria for Stage 3, was released as a separate rule, RIN 0991-AB93. It will not become effective until 90 days after publication, January 14, 2016.

- Comments are still being sought for specific provisions for Stage 3.
Attestation Schedule for 2015

- Rule does not list attestation timeline, but CMS has stated it will begin on January 4, 2016 – February 28, 2016 for 2015 attestations for both the hospitals and the EPs.

- MPIP (Ohio Medicaid) is reviewing the rule to determine what will change in the attestation process. MPIP hopes to have actual attestation timelines out soon.
Reporting Periods for 2015

Hospitals

- Move from fiscal year reporting (October 1-September 30) to calendar year reporting (January 1 – December 31) effective 2015.
- Can attest for any 90 day period from October 1, 2014-December 31, 2015.

Physicians/EPs

- Stay on same calendar year reporting cycle.
- Can attest for any 90 day period from January 1, 2015 – December 31, 2015.

No 2015 attestations for Medicare until January 4, 2016. Ohio Medicaid will announce attestation timeline shortly.
MU Modified Reporting for 2015-2017

**Blended Stage 1 & Stage 2 for 2015**
- One unified set of reporting measures with exclusions & alternate measures
- Any 90 days

**Blended Stage 1 & Stage 2 for 2016**
- One unified set of reporting measures with exclusions & alternate measures
- 1 year reporting

**Blended Stage 1 & Stage 2 OR Stage 3 for 2017**
- A. 2015 blended measures with fewer exclusions; 1 year reporting
- B. Stage 3 measures; 90 day reporting

OR
How MU Will Change in 2015

Blends Stage 1 & 2 into one set of measures with multiple exclusions & alternate measures

- No core & menu measures.
- 9 required EP measures + 2 public health/registry reporting measures.
- 8 required EH measures + 3 public health/registry reporting measures.
- All reporting will be 90 days.
- CQM reporting period does not need to coincide with MU period.
Measures Removed from Attestation

- Demographics
- Vital Signs
- Smoking Status
- Clinical Summaries
- Structured Lab Results
- Patient Lists
- Patient Reminders
- eMAR
- Advanced Directives
- Electronic Notes
- Imaging Results
- Family Health History
- Lab Results to Providers
- Printed Summary of Care
# Objectives for 2015-2017

<table>
<thead>
<tr>
<th></th>
<th>Objective</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Protect Electronic Health Information</td>
</tr>
<tr>
<td>2</td>
<td>Clinical Decision Support</td>
</tr>
<tr>
<td>3</td>
<td>Computerized Provider Order Entry (CPOE)</td>
</tr>
<tr>
<td>4</td>
<td>Electronic Prescribing (eRx)</td>
</tr>
<tr>
<td>5</td>
<td>Health Information Exchange</td>
</tr>
<tr>
<td>6</td>
<td>Patient-Specific Education</td>
</tr>
<tr>
<td>7</td>
<td>Medication Reconciliation</td>
</tr>
<tr>
<td>8</td>
<td>Patient Electronic Access</td>
</tr>
<tr>
<td>9</td>
<td>EP Secure Messaging</td>
</tr>
<tr>
<td>10</td>
<td>Public Health Reporting</td>
</tr>
</tbody>
</table>

+ Clinical Quality Measures Reporting
**OBJECTIVE 1:** Protect electronic health information created or maintained by the CEHRT through the implementation of appropriate technical capabilities.

**MEASURE:** Conduct or review a security risk analysis in accordance with the requirements in 45 CFR 164.308(a)(1), including addressing the security (to include encryption) of ePHI created or maintained by CEHRT in accordance with requirements and implement security updates as necessary and correct identified security deficiencies as part of the risk management process.

Rule now specifies information for reporting period for security reviews:

- “The security risk assessment is not an ‘episodic’ item related only to a snapshot in time, but should cover the entirety of the year for which the analysis or review is conducted.”

- “It is acceptable for the security risk analysis to be conducted outside the EHR reporting period if the reporting period is less than one full year. However, the analysis or review must be conducted within the same calendar year as the EHR reporting period, and if the provider attests prior to the end of the calendar year, it must be conducted prior to the date of attestation.”

- “An organization may conduct one security risk analysis or review which is applicable to all EPs within the organization, provided it is within the same calendar year and prior to any EP attestation for that calendar year.”
Clinical Decision Support

**OBJECTIVE 2:** Use clinical decision support to improve performance on high-priority health conditions. Must meet both measures to satisfy objective.

**MEASURE 1:** Implement 5 clinical decision support interventions related to 4 or more CQMs across 3 domains.
- Absent 4 CQMS, CDS must be related to high-priority health conditions.

**MEASURE 2:** Drug/Drug and Drug/Allergy interaction checking functionality enabled.

**STAGE 1 ALTERNATE:** Implement one CDS rule relevant to specialty or high clinical priority along with the ability to track compliance with that rule.

**EP EXCLUSION FOR DRUG/DRUG & DRUG/ALLERGY:** EP who writes < 100 medication orders during the reporting period.
**OBJECTIVE 3:** Use computerized provider order entry for medication, laboratory, and radiology orders directly entered by any licensed healthcare professional that can enter orders per state, local & professional guidelines.

**MEASURE 1:** > 60% of medication orders created by EP or by authorized providers of the EH’s inpatient or emergency department (POS 21 or 23) during the EHR reporting period are recorded using CPOE.

**MEASURE 2:** > 30% of laboratory orders created by EP or authorized providers of hospital’s inpatient or ED recorded using CPOE.

**MEASURE 3:** > 30% of radiology orders created by EP or authorized providers of hospital’s inpatient or ED are recorded using CPOE.

**STAGE 1 ALTERNATE EXCLUSION (2015 and 2016):** > 30% of medication orders recorded using CPOE; Exclusion for Lab & Rad orders.

**EP EXCLUSION:** EP who writes < 100 med orders, < 100 lab orders or < 100 rad orders during the reporting period is excluded from that particular measure.
CPOE Notes on Who May Enter

- References FAQ 9058: A licensed health care provider or a medical staff person may enter orders who is:
  - Credentialed medical assistant
  - Credentialed to and performs duties equivalent to credentialed medical assistant

- There must be a certain level of medical training to execute the related clinical decision support when orders are entered.

- Interns that have completed their medical training and are working towards licensure are included.

- In general, scribes are NOT included.

- Deference is given to the provider to determine the proper credentialing, training and duties for personnel entering the orders.

- Standing orders may be excluded.

- Telehealth or remote communication orders may be included if otherwise meet definition of CPOE.
EP Electronic Prescribing (eRx)

EP OBJECTIVE 4: Generate and transmit permissible prescriptions electronically (eRx).

EP MEASURE: > 50% of all permissible prescriptions are:
- Queried for drug formulary
- Transmitted electronically

EP EXCLUSION: EP who writes < 100 prescriptions during the reporting period.

EP STAGE 1 ALTERNATE EXCLUSION (2015 ONLY): > 40% of all permissible prescriptions written by the EP are transmitted electronically.
**EH OBJECTIVE 4:** Generate and transmit permissible discharge prescriptions electronically (eRx).

**EH MEASURE:** > 10% of all hospital discharge medication orders for permissible prescriptions (for new and changed prescriptions) are:
- Queried for a drug formulary
- Transmitted electronically

**EH EXCLUSION:** No internal pharmacy that accepts eRx and no pharmacy within 10 miles accepts eRx.

**EH ALTERNATE EXCLUSION (2015 and 2016):**
- EHs scheduled to demonstrate Stage 1 in 2015 or 2016 may claim an exclusion to this measure.
- EHs scheduled to demonstrate Stage 2 in 2015 or 2016 may claim an exclusion if not intending to attest to the eRx menu measure.
OBJECTIVE 5: The EP/EH who transitions a patient to another setting of care or provider of care or refers their patient to another provider of care provides a summary of care record for each transition of care or referral.

MEASURE: The EP or EH that transitions or refers patients to another setting or care or provider of care must: 1) must use CEHRT to create a C-CDA and 2) must electronically transmit the C-CDA for > 10% patients transitioned/referred.

EP EXCLUSION: EP who transitions < 100 patients during the reporting period.

EP/EH STAGE 1 ALTERNATE EXCLUSION (2015 ONLY): May claim an exclusion if the provider was to report Stage 1.
Health Information Exchange

Information to be included in C-CDA is the same as Stage 2 measure:

Required fields:
- Problem list
- Meds list
- Med allergy list

Required fields if information available:
- Patient name
- Referring provider’s name and contact information
- Procedures
- Encounter diagnosis
- Immunizations
- Lab tests
- Vital signs
- Smoking status
- Functional status
- Demographics
- Care plan field and care team
- Discharge instructions (EH), Reason for referral (EP)
Health Information Exchange

Information can be limited in C-CDA to information that is clinically relevant, specifically:

- Lab results that best represent the patient status upon admission, any abnormal results, and patient status upon discharge.
- Provider’s CEHRT must have ability to send all lab results
- If receiving provider or patient requests it, all lab results must be sent.
OBJECTIVE 6: Use clinically relevant information from CEHRT to identify patient-specific education resources and provide those resources to the patient.

MEASURE: > 10% patients seen/discharged provided education resources identified by CEHRT.

EXCLUSION: EPs who have no office visits during the reporting period.

STAGE 1 ALTERNATE EXCLUSION (2015 ONLY): May claim an exclusion if not intending to select patient education menu measure.
### Medication Reconciliation

**OBJECTIVE 7**: The EP/EH who receives a patient from another setting of care or provider of care or believes an encounter is relevant should perform medication reconciliation.

<table>
<thead>
<tr>
<th>MEASURE:</th>
<th>&gt; 50% of transitions of care into practice/admitted to facility’s inpatient or ED (POS 21 or 23) perform medication reconciliation.</th>
</tr>
</thead>
<tbody>
<tr>
<td>EXCLUSION (EP):</td>
<td>Any EP who was not the recipient of any transitions of care during the reporting period.</td>
</tr>
<tr>
<td>STAGE 1 ALTERNATE EXCLUSION (2015 ONLY):</td>
<td>May claim an exclusion if not intending to select med rec as a menu measure.</td>
</tr>
</tbody>
</table>
Medication Reconciliation

“We believe that it is appropriate and important to conduct medication reconciliation for each patient regardless of the method that reconciliation may require.”

Different forms of med rec:
- Automated inclusion of ePHI
- Review of paper records
- Discussion with the patient upon intake
- During consultation with the provider

Calculate by the patient, not by the documents received: If receive duplicate summaries of care for a single referral, med rec is only counted once.

Counts whether there are changes or no changes in the med list.
EP Patient Electronic Access

OBJECTIVE 8: Provide patients the ability to view, download and transmit health information within 4 business days of the information being available for EP or 36 hours of discharge for EH.

<table>
<thead>
<tr>
<th>EP MEASURE 1 (Access):</th>
<th>&gt; 50% of patients seen have access to their information within 4 business days of availability subject to EP’s discretion to withhold certain information.</th>
</tr>
</thead>
</table>
| EP MEASURE 2 (VDT):    | - **2015 and 2016:** At least 1 patient (or patient authorized representative) views/downloads/transmits record.  
                        | - **2017:** > 5% of patients seen during the reporting period VDT their health information. |
EP Patient Electronic Access

To meet the measure, the following information must be provided within 4 business days of information being made available:

- Patient name
- Referring provider’s name and contact information
- Current and past problem list
- Procedures
- Lab tests
- Current meds and med history/include med allergy and allergy history
- Vital signs
- Smoking status
- Demographics
- Care plan field and care team
## EH Patient Electronic Access

**OBJECTIVE 8:** Provide patients ability to view, download and transmit health information within 4 business days of the information being available for EP or 36 hours of discharge for EH.

<table>
<thead>
<tr>
<th>EH MEASURE 1 (Access):</th>
<th>&gt; 50% of unique patients discharged from inpatient or ED (POS 21 or 23) have access to their information within 36 hours of availability.</th>
</tr>
</thead>
</table>
| EH MEASURE 2 (VDT):    | 2015 and 2016: At least 1 patient (or patient authorized representative) views/downloads/transmits record.  
                        | 2017: > 5% of patients seen during the reporting period VDT their health information.                                           |
| EH STAGE 1 ALTERNATE EXCLUSION (2015 only): | May claim an exclusion for VDT (Measure 2). |
To meet the measure, the following information must be provided within 36 hours of discharge:

- Patient name
- Admit and discharge date and location
- Reason for hospitalization
- Current and past problem list
- Procedures
- Lab tests available at discharge
- Current meds and med history/include med allergy and allergy history
- Vital signs at discharge
- Smoking status
- Demographics
- Care plan field and care team
- Discharge instructions
- Summary of care record for transitions of care or referrals
EP Secure Messaging

| EP OBJECTIVE 9: Use secure electronic messaging to communicate with patients on relevant health information. |
| EP MEASURE: |
| 2015: Secure messaging capability was fully enabled during the reporting period. |
| 2016: For at least 1 patient seen during the reporting period a secure message was sent to the patient using the electronic messaging function of the CEHRT or was sent in response to a patient-initiated secure message. |
| 2017: For > 5% of patients seen during the reporting period a secure message was sent to the patient using the electronic messaging function of the CEHRT or was sent in response to a patient-initiated secure message. |

| EP EXCLUSION: EPs who have no office visits or conducts > 50% of encounters in county with limited broadband availability as identified by FCC. |

EP Public Health Reporting

**EP OBJECTIVE 10:** The EP is in active engagement with a Public Health Agency (PHA) to submit electronic public health data from CEHRT except where prohibited and in accordance with applicable law & practice.

<table>
<thead>
<tr>
<th>Must meet 2 measures for public health reporting by having active engagement with agency for:</th>
</tr>
</thead>
<tbody>
<tr>
<td>▪ Immunization reporting</td>
</tr>
<tr>
<td>▪ Syndromic surveillance reporting</td>
</tr>
<tr>
<td>▪ Specialized registry reporting (can include 2)</td>
</tr>
</tbody>
</table>

**EP STAGE 1 ALTERNATE SPECIFICATION (2015 ONLY):** Must meet 1 measure

**IMMUNIZATION EXCLUSION:**

- Does not administer immunizations for population where data is collected in Ohio

**SYNDROMIC SURVEILLANCE EXCLUSION:**

- Is not in a category of providers from which ambulatory syndromic surveillance data is collected

**SPECIALIZED REGISTRY EXCLUSION:**

- Doesn’t diagnose or treat disease or collect relevant data that is required by a specialized registry
EH OBJECTIVE 10: The EH is in active engagement with a Public Health Agency (PHA) to submit electronic public health data from CEHRT except where prohibited and in accordance with applicable law & practice.

<table>
<thead>
<tr>
<th>Must meet 3 measures for public health reporting by having active engagement with agency for:</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Immunization reporting</td>
</tr>
<tr>
<td>- Syndromic surveillance reporting</td>
</tr>
<tr>
<td>- Specialized registry reporting (can include 3)</td>
</tr>
<tr>
<td>- Electronic reportable lab (ELR) results</td>
</tr>
</tbody>
</table>

EH STAGE 1 ALTERNATE SPECIFICATION (2015 ONLY): Must meet 2 measures

<table>
<thead>
<tr>
<th>IMMUNIZATION EXCLUSION:</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Does not administer immunizations for population where data is collected in Ohio</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>SYNDROMIC SURVEILLANCE EXCLUSION:</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Does not have an emergency or urgent care department</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>SPECIALIZED REGISTRY EXCLUSION:</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Does not diagnose or treat any disease or condition associated with or collect relevant data that is required by a specialized registry in Ohio during the reporting period</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>ELECTRONIC REPORTABLE LAB RESULT REPORTING:</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Does not perform or order laboratory tests that are reportable in Ohio during the reporting period</td>
</tr>
</tbody>
</table>
Clinical Quality Reporting

CQM reporting is finalized for 2015 as the same as 2014 reporting:

- EPs need to report 9 CQMs across 3 domains
- EHs need to report 16 CQMs across 3 domains

Type of Reporting:

- In 2015, can attest to a 90 day reporting period for CQMs
- In 2016, can attest to a one year reporting period for CQMs
- In 2017, can either attest or submit eCQMs
- In 2018, must submit eCQMs
Information on current Meaningful Use requirements and attestation regulations.
Customized education for practices and hospital personnel on MU strategies and timelines.
Resources to help you understand quality reporting for PQRS and GPRO reporting.
Guidance on using your Quality and Resource Use Report (QRUR) to maximize Medicare reimbursements.
Ohio-specific information on Public Health Reporting from the Ohio Department of Health and attestation updates from the Ohio Department of Medicaid.
Education on “mock” audits for various reporting programs.
Cathy Costello
614-664-2607
ccostello@ohiponline.org

Scott Mash
614-541-2296
smash@ohiponline.org

www.clinisync.org
While visiting our website don’t forget to sign up for our newsletter!