



MEANINGFUL USE (MU)


**One Journey
Many Paths
Eligible Providers (EPs)**

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Conceptual Approach to Meaningful Use

Data capture and sharing → Advanced clinical processes → Improved outcomes



Origins of MU

- **The American Reinvestment & Recovery Act (ARRA) Legislation**
 - Enacted 2/27/2009:
 - ONE FEATURE: Health Information Technology for Economic and Clinical Health(HITECH): Supports the Use Electronic Health Records



- **Under Centers of Medicare and Medicaid (CMS)**



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Goals Of MU

- Improve Quality, Safety, Efficiency and Reduce Health Disparities.
- Engage patients and family's in decisions
- Improve care coordination
- Improve Public Health
- Ensure Privacy and Security (Ransomware) for PHI
- Clinical Effectiveness

CAPTURE & SHARE DATA
IMPROVE CLINICAL PROCESS
IMPROVE OUTCOMES

Goals

1. _____
2. _____
3. _____



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CARROT BEFORE THE STICK

- **Incentives for Adoption**
 - **Three years of incentives**
 - **Core Measures**
 - **CQM-Clinical Quality Measures**
- **Then the Stick-Penalized 3% and upward**



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High Risk Medications in Elderly
Documentation of Current Medications in the medical record (Up to date med list)
Documentation of tobacco use
Documentation of Influenza immunization
BMI screening
Pneumonia vaccine

Meaningful Use
MU2 objectives are the measurable benchmarks that EPs and EHs/CAHs must meet in adopting and using electronic health record (EHR) technology to qualify for Medicare and Medicaid incentive payments

CLINICAL QUALITY MEASURES

MU2 sets measurable objectives for Eligible Professionals (EPs) or Eligible Hospitals (EHs) / Critical Access Hospitals (CAHs) to obtain CMS incentives (CMS 495.6)

- MU2 objectives are categorized to reflect Health Outcomes Policy Priorities
- Pursuit of objectives within 2 of the 7 categories involve using Certified EHR Technology that has C-CDA capabilities

Office of the National Coordinator for Health Information Technology

6

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MU GETTING STARTED

Health Information Management

Organize Engagement With Departments
Meeting Weekly

AT THE TABLE

MD(CMIO), HIM, Quality Improvement,
Nursing-Informatics, Admissions, IST,
Marketing, Physician Professional
Development.

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2014




Aligning the EHR with MU measures MU Reporting Package

- Challenges
 - **Provider Buy In** “Why are we doing this?”
 - **Department Buy In** Education on participation
 - **Learning the Technology** Training and Education on the EHR





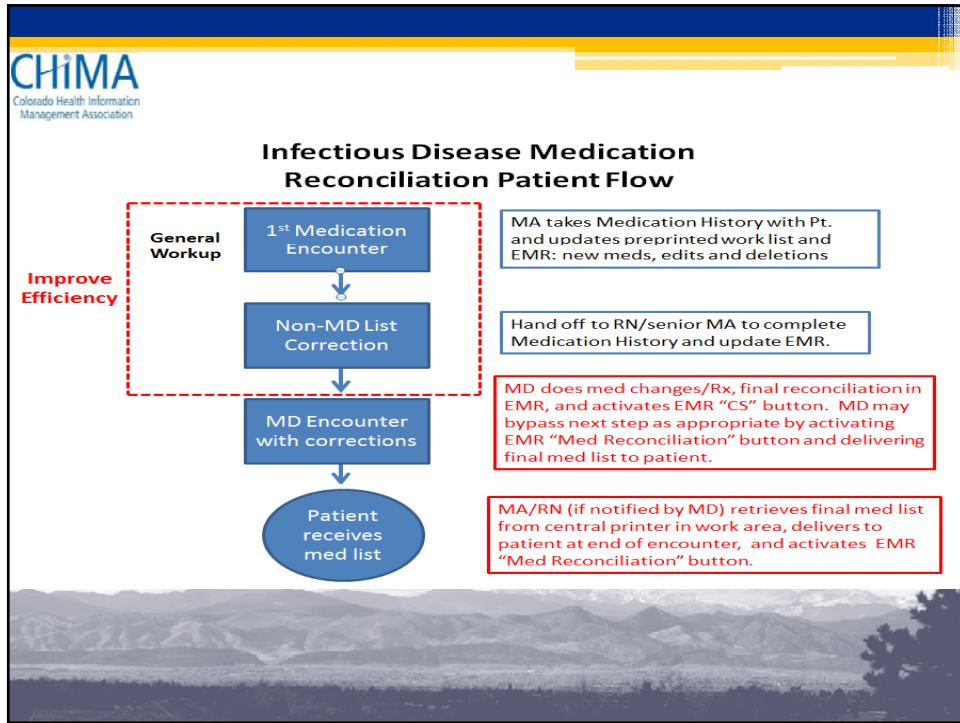
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Other Concerns:

- **Responsibility vs. Accountability**
 - Meeting measures with a click vs actually doing the requirement to help improve patient care. Ex:
 - **CCDA Summary** – (Consolidated Clinical Document Architecture)
One clinic was printing them to the waste basket-not handing to the patient
 - **Medication Reconciliation** – MA starts the process (responsibility) but the physician is ultimately Accountable.





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RECOMMENDATIONS

Designate a person at each site to hold providers accountable for compliance.

STIMULUS REPORT:

- Run attestation reports prior to the qualifying period by provider; identify problem areas and remediate
- Run the attestation reports weekly during the attestation period



RECOMMENDATIONS CONT.

CYA AUDITS:

- Maintain attestation reports and supporting documentation, for six years in preparation for potential CMS audit

EDUCATION: (Net-Learning, CBTs, Hands On)

- Reinforcement/Educate Eligible Providers (EPs)



2015




- **Meaningful Use Coordinator** hired 7/2015- still waiting for the final rule from CMS.
 - Studied each rule and dove into the measure logic from Allscripts
- **Final Rule** was published 10/2015
 - Finally able to focus on EP performance and address issues
- **Determine Attesting Providers**
 - Total Medicare charges vs. the cost to attest
 - Final decision 73 EPs of 110 EPs



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Measures Included:


- 1. Protect Patient Health information (security risk analysis performed)- yes/no attestation**
- 2. CLINICAL DECISION SUPPORT-**
 - **Computerized Alerts for Physicians and Patients**
 - **Condition Specific Order Sets**
 - **Diagnostic Support (Ex: Labs flagged in red)**
 - **A tool to assist care teams**
2015 Implemented 1 CDS tool
2016- Implemented 5 CDS tools




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MEASURES CONT.

- 3. Computerized Provider Order Entry (CPOE) Medication orders, lab orders and radiology orders.**
- 4. e-Prescribing (eRx)**






5. Health information exchange (Direct messaging) Exclusion for 2015

6. Patient-specific education- Exclusion for 2015


7. Medication reconciliation- "menu measure" Completed



8. Patient electronic access (portal)- we took exclusion for 2015



9. Secure electronic messaging-2015 Exclusion

10. Public Health Reporting (Immunization, Syndromic Surveillance or Specialized registry)- attested for Immunization registry for 2015. 2016- Immunization and CDC for specialized registry.




Example of MU report

Provider	obj 3.1				obj 3.2				obj 3.3				obj 4				Rec
	CPOE Medication				CPOE Lab				CPOE Radiology				Electronic Prescribing				
	Nur	De	Exc	Scor	Nur	De	Exc	Scor	Nur	De	Exc	Scor	Nur	De	Exc	Scor	Nur
8	71	77	100	92.21%	87	87	100	100.00%	35	35	100	100.00%	43	71	100	60.56%	0
9	21	23	100	91.30%	43	43	100	100.00%	49	49	100	100.00%	11	23	100	47.03%	1
10	189	190	100	99.47%	234	234	100	100.00%	168	168	100	100.00%	161	185	100	87.03%	18
11	40	40	100	100.00%	9	9	100	100.00%	3	3	100	100.00%	35	40	100	87.50%	3
12	323	326	100	99.08%	353	353	100	100.00%	114	114	100	100.00%	265	294	100	90.14%	11
13	16	16	100	100.00%	353	353	100	100.00%	113	113	100	100.00%	12	16	100	75.00%	10
14	191	197	100	96.95%	330	330	100	100.00%	56	56	100	100.00%	164	182	100	90.11%	29
15	81	89	100	91.01%	83	83	100	100.00%	83	83	100	100.00%	61	79	100	77.22%	20
16	73	74	100	98.65%	46	46	100	100.00%	10	10	100	100.00%	55	70	100	78.57%	2
17	295	299	100	98.66%	126	126	100	100.00%	23	23	100	100.00%	249	283	100	87.99%	7
18	83	83	100	100.00%	85	85	100	100.00%	35	35	100	100.00%	58	79	100	73.42%	5
19	207	208	100	99.52%	89	89	100	100.00%	25	25	100	100.00%	161	193	100	83.42%	11
20	1	1	100	100.00%	4	4	100	100.00%	15	15	100	100.00%	0	0	100	0.00%	3
21	34	34	100	100.00%	20	20	100	100.00%	41	41	100	100.00%	23	33	100	69.70%	7
22	252	274	100	91.97%	181	181	100	100.00%	28	28	100	100.00%	229	260	100	88.08%	29
23	297	309	100	96.12%	86	86	100	100.00%	84	84	100	100.00%	237	293	100	80.89%	11
24	119	122	100	97.54%	159	159	100	100.00%	88	88	100	100.00%	89	111	100	80.18%	23
25	36	36	100	100.00%	19	19	100	100.00%	4	4	100	100.00%	10	15	100	66.67%	47
	38	38	100	100.00%	33	33	100	100.00%	13	13	100	100.00%	26	37	100	70.27%	6

Developing/Altering workflows



- **Workflows have been technically built around MU ex: CPOE. Providers do not have an alternative but to use.**
- **Other workflows were modified to meet MU ex: eRx, Medication Reconciliation and Patient Education**



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Improving Performance/Quality Meeting MU Requirements



- **Through EHR reporting portal Identified EPs not meeting to reflect the final rule.**
- **One Measure: Medication Reconciliation. Not meeting due to inconsistencies:**
 - Workflow breakdowns
 - “I need to click WHAT?”



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DIRECT MESSAGING

- **DIRECT WHAT???**
- **Sending a message directly from one EMR to another EMR.**
- **Similar to email, but more secure and direct**
- **Potentially flows directly into patient chart**



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DIRECT MESSAGING CONT.



- **Every Attesting Provider Receives Direct Message Address**
- **Improves coordination of care**
- **Quickly share patient information**





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DIRECT MESSAGING


- **Establishing communication directly with other systems.**
“Let’s Talk”
 - **Developing Workflow:**
 - **Sending Out:**
Off ground referral process (consults, tests, and procedures) so we can send direct messages.
 - **Incoming Information-From Inpatient Stays**
 - **Releasing Information to our DM Partners**
 - **Incorporates systems, people, process.**
 - **This has been a very challenging process!**





CHALLENGES INCLUDE:

- **Technology:**
 - **Unable to attach to outgoing**
 - **Unable to receive incoming attachments**
 - **Communicating with other providers to verify they can receive.**
 - **Testing**



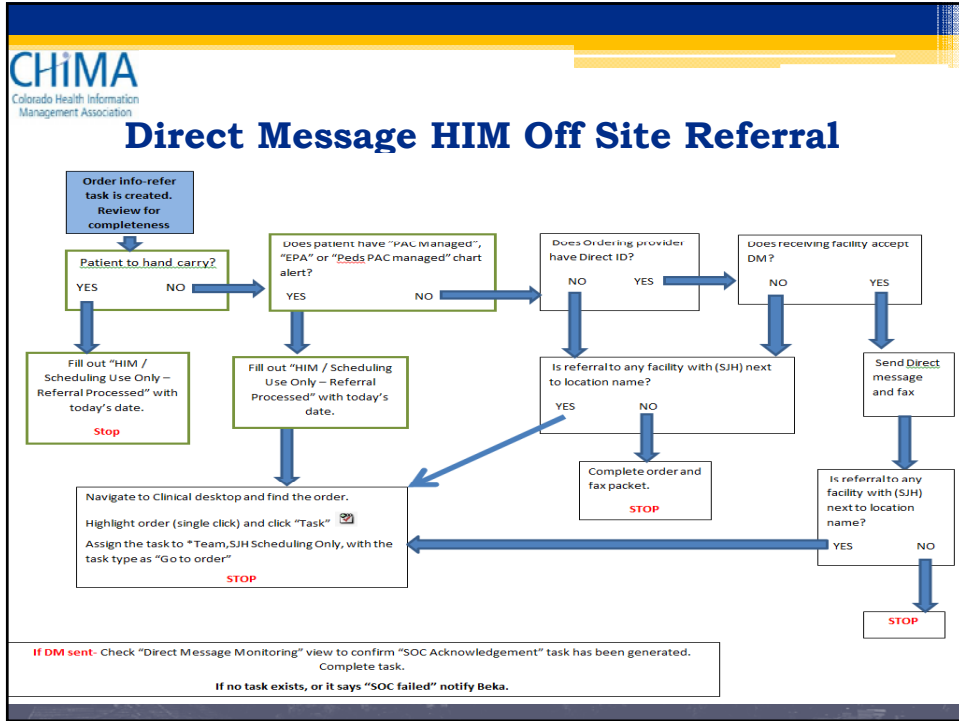
Direct messaging/HIE/MU Objective 5

PROCESS:

- **Simple process adding direct messages to our order.**
- **We were WRONG!**
 - **We met monthly or every 2 weeks for a year.**
 - **Involved Admissions, Scheduling and Marketing, to help finalize workflow and building orders.**
 - **Establish relationships with providers to test if our redesigned workflow actually worked!**

(How is it going?)






MU FUTURE CONSIDERATIONS:

- **Managing Attestation on the provider level.**
- **Provider fails MU and moves to another facility? Payment adjustment follows them!**

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MU FUTURE CONSIDERATIONS:

- **Hiring- Soon facilities will need to ask about a provider's MU success when hiring, will they be bringing a penalty with them?**
- **Audits- EP gets audited and fails, who gives money back?**





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November 1st is the deadline for the final measures and policies of MIPS

MU Future

- **MACRA-(Medicare Access and CHIP Reauthorization Act of 2015)**
 - **Streamlines multiple quality programs under the new MIPS (Merit-Based Incentive Payments Systems) program**


Consolidates MU, PQRS (Physician Quality Reporting System) and Value-Based Payment Modifier into a combined performance score.



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****Breaking News****

- **CMS blog post on 4/27/2016 (900 page proposed rule)**
- **Proposed rule will change the name of MU to “Advancing Care Information”**
 - **Choose measures?**
 - **Eliminate all or nothing measurement?**
 - **Reduce measures to 11?**
 - **Report as a group instead of EPs?**
 - **Eliminate CDS and CPOE measures?**



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MIPS



QUALITY PAYMENT PROGRAM clinician driven • patient centered



- **Include 4 performance categories with weighted values:**
 - **50% = Quality- 6 PQRS measures**
 - **10% = Resource Use- Based on claims data, no reporting requirement**
 - **15% = Clinical Practice Improvement Activities- NEW**
 - **25% = Advancing Care Information- AKA Meaningful Use!**

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MU FUTURE CONT.

- **Payment adjustments can be positive, negative or neutral. Amount starts at 4% and will go up to 9%.**
 - Score will be compared to a threshold determined by CMS, so providers can tell if they are passing or failing right away.
- **Will include MDs, PAs, NPs, Clinical Nurse Specialists and Nurse Anesthetists.** (Maybe not for 1st year?)
- ****MIPS will not apply to hospitals or facilities, EPs only.**

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Questions/Comments/Experiences

- Comment on CMS Proposed Rule PLEASE!!
 - <https://go.cms.gov/QualityPaymentProgram>
- Start a blog/group to share experiences?
- Make connections and learn from each other.






Email Addresses:

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CMS Websites:

• <http://www.cms.gov/EHRIncentivePrograms/>

• https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/downloads/EP_Attestation_User_Guide.pdf

• https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/HIMSS16_101MIPSListingSession.pdf

• <http://www.hhs.gov/about/news/2016/04/27/administration-takes-first-step-implement-legislation-modernizing-how-medicare-pays-physicians.html>

• <http://go.cms.gov/QualityPaymentProgram>