Understanding the EHR Incentive Program

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Objectives

- Understand the new EHR Incentive program requirements
- Know what to do to prepare to meet the new requirements
- Understand the impact this will have on your EHR technology, your staff and your workflow
Meaningful Use Outline

• A reminder of why we are doing this
• Changes to the timeline
• Clarification of the penalties
• New requirements and options for stage 1
• Stage 2 requirements
• New quality measurement requirements starting in 2014 for all
• What you need to do now
From the Health and Human Services Web Site:

- “Health information technology (health IT) makes it possible for health care providers to better manage patient care through secure use and sharing of health information.
- Health IT includes the use of electronic health records (EHRs) instead of paper medical records to maintain people's health information.”

  - A randomized controlled clinical trial of order writing on computers resulted in
    - Charges that were **12.7%** lower per admission
    - Significant reductions for bed charges, diagnostic test charges and drug charges.
    - A mean length of stay was 0.89 day shorter

  - Random-selection study to compare antibiotics suggested by the antibiotic consultant with those ordered by physicians demonstrated a **17% greater pathogen susceptibility** to an antibiotic drug regimen suggested by a computer consultant vs. a physician

  - Pre and post intervention study alerting for drug allergies, excessive dosages, antibiotic-susceptibility, lack of appropriateness and patients' renal function
  - Faster retrieval of relevant patient-specific information 14 minutes vs. 3.5 seconds
  - **Reductions in erroneous orders** for drugs where the patients had
    - Adverse Drug Event 70%
    - Reported allergies: 76%
    - Excess drug dosages 79%
    - Antibiotic-susceptibility mismatches 94%

  – Assessing the impact of CPOE with CDSSs in a before-after comparison study demonstrated a **55% decrease in non intercepted serious medication errors**

  – Evaluated medication error rates before CPOE and in the 3 years subsequent to its implementation. It demonstrated an 81% decrease in medication errors and an **86% decrease in non intercepted serious medication errors** (*P*<.001 for both)

  – Greater than **25% improvement in the rates of corollary orders** with implementation of computerized reminders.
Institute of Medicine, Sept 1999

- At least 44,000 people, and perhaps as many as 98,000 people, die in hospitals each year as a result of medical errors that could have been prevented.
- Using the lower estimate, preventable medical errors in hospitals exceed attributable deaths to such feared threats as motor-vehicle wrecks, breast cancer, and AIDS.
- The equivalent of one jumbo jet falling out of the sky every day.
Continued Evidence of CPOE Benefits Pre/Post Intervention Studies (2002-2005)

  - A 64% improvement in medication turn-around times, 43% in radiology procedure completion times, and 25% in laboratory result reporting times

  - An overall error reduction of 95.9% with ADEs reduced by 40.9%, Medication prescribing errors reduced by 99.4% and rule violations reduced by 97.9%.

  - Reduced risk of deep-vein thrombosis or pulmonary embolism at 90 days by 41%

  - A 43% reduction in preventable ADEs and 63% reduction in potential ADEs
Health Information Technology and Quality, Efficiency and Cost (2006)


- 257 studies met the inclusion criteria of which 25% were from 4 academic institutions with internally developed systems
  - Brigham and Women's Hospital in Boston
  - LDS Hospital in Salt Lake City
  - Vanderbilt University Medical Center in Nashville
  - The Regenstrief Institute in Indianapolis

- Those 4 institutions (and only those 4) demonstrated
  - Benefits on quality:
    - Increased adherence to guideline-based care
    - Enhanced surveillance and monitoring
    - Decreased medication errors.
  - Benefit of improvement
    - Preventive health (DVT, pressure ulcers and post-op infections)
  - Efficiency benefit
    - Decreased utilization of care.
EHRs: Problems with Commercial Installations (2005 – 2007)

  – The rapid implementation of a minimally modified, commercially available CPOE system in a pediatric critical care unit was associated with an *increase in mortality rate* for children admitted via interfacility transport over a 5-month period.

  – Evaluated 50,000 patient records from over 1500 physician practices in 2003 and 2004 and found: “As implemented, EHRs were *not associated with better quality* ambulatory care.”
  – Acknowledged the positive information came from 4 “benchmark” institutions.
Local Customization of CPOE Improves Quality (2010 – 2012)

  - Pre and Post implementation of a locally modified CPOE and electronic nursing documentation system at quaternary care academic children's hospital demonstrated a monthly adjusted mortality rate decreased by 20%.

  - A review of 148 randomized, controlled trials of electronic CDSSs implemented in clinical settings, used at the point of care and reported either clinical, health care process, workload, relationship-centered, economic, or provider use outcomes.

  - Both commercially and locally developed clinical decision-support systems (CDSSs) showed statistical significance in improved health care process measures related to performing preventive services, ordering clinical studies and prescribing therapies across diverse settings.
EHRs and Quality (2012)

  - Reduced risk of deep-vein thrombosis or pulmonary embolism at 90 days by 41%.

  - Significantly higher quality of care for hemoglobin A1c testing in diabetes, breast cancer screening, chlamydia screening and colorectal cancer screening.

  - Statistically significant reductions in HbA1c and LDL-C levels, with the largest reductions among patients with the worst control.
Per Capita Health Expenditure vs. Life Expectancy

Life expectancy at birth, years

Total expenditure on health per capita, US $ PPP

1. Or latest year available.
Source: OECD Health Data 2010.
The Bi-Partisan Support:

2004 “…an Electronic Health Record for every American by the year 2014. By computerizing health records, we can avoid dangerous medical mistakes, reduce costs, and improve care.” George W Bush - State of the Union address, Jan. 20, 2004

2009 “Computerize all health records within five years.” Barack Obama - George Mason University, January 12, 2009
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# Stages of Meaningful Use Under Medicare

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<td>1</td>
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<td>2</td>
<td>3</td>
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<td>2015</td>
<td>1</td>
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<td>2</td>
<td>2</td>
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<td>2016</td>
<td>1</td>
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<td>2</td>
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<td>2017</td>
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1. Note: Under Medicaid, if a Medicaid only provider does not receive a payment for that year, the stage of MU does not progress.
Incentives

- Medicare and Medicaid incentives are unchanged from the Stage 1 Rule
- Some broadening of Medicaid eligibility
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EHR Reporting Period

- EPs who demonstrate meaningful use in 2011 through 2013 calendar years will not be penalized 2 years later

<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>
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<tbody>
<tr>
<td>EHR Reporting Period</td>
<td>2013</td>
<td>2014</td>
<td>2015</td>
<td>2016</td>
<td>2017</td>
<td>2018</td>
</tr>
</tbody>
</table>

- For EPs who demonstrates meaningful use in 2014 or later for the first time (using 2014 as an example):

<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>90 day EHR Reporting Period</td>
<td>2014*</td>
<td>2014</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Full Year EHR Reporting Period</td>
<td>2015</td>
<td>2016</td>
<td>2017</td>
<td>2018</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* If the EP attests no later than the October 1 before the penalty year
EP Medicare Payment Adjustments

• For the EP starting in 2015:
  – If > 75% of EPs are meaningful users, allowable charges will be reduced 1%/year to a max of 3%
  – If < 75% of EPs are meaningful users, again 1%/year with a maximum reduction of 5%

• Hardship exemptions will be available by request
Changes to Stage 1

• CPOE:
  – Starting in 2013 option of 30% of all medication orders
• Vital Signs:
  – Optional in 2013 and required in 2014:
    • ≥ 3 for BP; all ages for height/length & weight; growth charts ≤ 20
    • May claim exclusion for H/L&W or BP or both
• Test of exchange and the yes/no measure “Reporting CQMs”:
  – Removed for 2013
• Electronic copies and access:
  – 2 measures replaced in 2014 with online view, download and transmit
• Public Health Measures:
  – “…except where prohibited…” added to the requirements
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Concepts for the Updated Meaningful Use Rules

• For both stages:
  – More exchange
  – More patient online access and involvement

• For Stage 2:
  – Stage 1 menu items have become core
  – Percentages have increased
  – Turnaround time is shorter
  – Some measures incorporated into others
Stage 1 and Stage 2 Meaningful Use for 2014

Eligible Professionals
- 13 core objectives
- 5 of 9 menu objectives
- 18 total objectives

Eligible Professionals
- 17 core objectives
- 3 of 6 menu objectives
- 20 total objectives
Stage 1 and 2 Core Objectives

1. Use CPOE > 60% of all medication orders, and >30% of all laboratory and radiology orders
2. Record demographics > 80%
3. Record Problems > 80% *
4. Record Medications > 80% *
5. Record Allergies > 80% *

* Problems, Meds and Allergies incorporated into the transfer of care document
Stage 1 and 2 Core Objectives

6. Record vital signs > 50% 80%
7. Record smoking status > 50% 80%
8. E-Rx > 40% 65%
9. Implement 1-5 clinical decision support interventions + drug/drug and drug/allergy
10. Provide visit summaries for >50% of office visits within in 72 hours 1 business day
11. Conduct or review security analysis and incorporate in risk management process
Stage 1 Menu and Stage 2 Core Objectives:

12. Incorporate lab results > 40 55%
13. Generate at least one patient list by a specific condition
14. Use EHR to identify and provide education resources > 10% of unique patients
15. Medication reconciliation > 50% of transitions of care (or all relevant encounters if there is a policy for this)
16. Use EHR to identify and provide > 10% with reminders for preventive/follow-up
17. **Successful ongoing** transmission of immunization data
18. Provide summary of care document > 50% of transitions of care and referrals...
New Stage 2 Core Objective:

18. Provide summary of care document > 50% of transitions of care and referrals with > 10% sent electronically and 1 to another organization with a different vendor’s EHR

19. Provide online access to health information > 50% with > 5% actually accessing it

20. More than 5% of patients send a secure messages to their EP
Stage 1 Core Measures Incorporated Into Others

- In order to meet the Transition of Care / Referral measure, must contain an up-to-date problem list, medication list and allergy list whether or not they are electronically transferred.
Elements of the Transfer of Care / Referral Summary Document

Usual Suspects
- Patient name.
- Referring or transitioning provider's name and office contact information (EP only).
- Procedures.
- Immunizations.
- Laboratory test results.
- Vital signs.
- Smoking status.
- Demographic information.
- Discharge instructions (Hospital Only).
- Reason for Referral (EP)

New Elements:
- Encounter diagnosis.
- Functional status, including activities of daily living, cognitive and disability status.
- Care plan field, including goals and instructions.
- Care team including the primary care provider of record and any additional care team members beyond the referring or transitioning provider and the receiving provider.
Stage 2 Menu Objectives
(Select 3 of 6)

1. More than 10% of imaging results are accessible through Certified EHR Technology
2. Record electronic notes in patient records for >30% of unique patients
3. Record family health history > 20%
4. Successful ongoing transmission of syndromic surveillance data
5. Successful ongoing transmission of cancer case information
6. Successful ongoing transmission of data to a specialized registry
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Clinical Quality Measures

Prior to 2014:
- EPs
- Report 6 out of 44 CQMs
  - 3 core or alt. core
  - 3 menu

Beginning in 2014:
- EPs
- Report 9 out of 64 CQMs
  - Selected CQMs must cover at least 3 of the 6 NQS domains
  - Recommended core CQMs:
    - 9 for adult populations
    - 9 for pediatric populations

National Quality Strategy domains (NQS):
1. Patient and Family Engagement
2. Patient Safety
3. Care Coordination
4. Population and Public Health
5. Efficient Use of Healthcare Resources
6. Clinical Processes/Effectiveness
CQM Specifications

• No change in specifications for the CQMs in 2013
• For EPs starting in 2014
  – 32 of the 44 CQMs finalized in the Stage 1 final rule will remain
  – 32 new CQMs will be added totalling 64
# 2013 Core Quality Measures for EPs

<table>
<thead>
<tr>
<th>Measure Number</th>
<th>Clinical Quality Measure Title</th>
</tr>
</thead>
<tbody>
<tr>
<td>NQF 0013</td>
<td>Blood pressure measurement</td>
</tr>
<tr>
<td>NQF 0028</td>
<td>Tobacco use assessment and intervention</td>
</tr>
<tr>
<td>NQF 0421 PQRI 128</td>
<td>Adult Weight Screening and Follow-up</td>
</tr>
</tbody>
</table>

**Alternate Core Measures**

<table>
<thead>
<tr>
<th>Measure Number</th>
<th>Clinical Quality Measure Title</th>
</tr>
</thead>
<tbody>
<tr>
<td>NQF 0024</td>
<td>Weight Assessment and Counseling for Children and Adolescents</td>
</tr>
<tr>
<td>NQF 0041 PQRI 110</td>
<td>Influenza Immunization for Patients ≥ 50 Years Old</td>
</tr>
<tr>
<td>NQF 0038</td>
<td>Childhood Immunization Status</td>
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</tbody>
</table>
2014 CQMs Recommended for Adults

<table>
<thead>
<tr>
<th>Category</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>Patient and Family Engagement.</td>
<td>Functional status assessment for complex chronic conditions</td>
</tr>
<tr>
<td>Patient Safety.</td>
<td>Use of High-Risk Medications in the Elderly</td>
</tr>
<tr>
<td></td>
<td>Documentation of Current Medications in the Medical Record</td>
</tr>
<tr>
<td>Care Coordination.</td>
<td>Closing the referral loop: receipt of specialist report</td>
</tr>
<tr>
<td>Population/Public Health.</td>
<td>Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention</td>
</tr>
<tr>
<td></td>
<td>Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up</td>
</tr>
<tr>
<td></td>
<td>Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan</td>
</tr>
<tr>
<td>Efficient Use of Healthcare Resources.</td>
<td>Use of Imaging Studies for Low Back Pain</td>
</tr>
<tr>
<td>Clinical Process/Effectiveness.</td>
<td>Controlling High Blood Pressure</td>
</tr>
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</table>
## 2014 CQMs Recommended for Children

<table>
<thead>
<tr>
<th>Population/Public Health.</th>
<th>Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Chlamydia Screening for Women</td>
</tr>
<tr>
<td></td>
<td>Childhood Immunization Status</td>
</tr>
<tr>
<td></td>
<td>Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan</td>
</tr>
<tr>
<td>Efficient Use of Healthcare Resources.</td>
<td>Appropriate Testing for Children with Pharyngitis</td>
</tr>
<tr>
<td></td>
<td>Appropriate Treatment for Children with Upper Respiratory Infection (URI)</td>
</tr>
<tr>
<td>Clinical Process/Effectiveness.</td>
<td>Use of Appropriate Medications for Asthma</td>
</tr>
<tr>
<td></td>
<td>ADHD: Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication</td>
</tr>
<tr>
<td></td>
<td>Children who have dental decay or cavities Description: Percentage of children ages 0-20, who have had tooth decay or cavities during the measurement period.</td>
</tr>
</tbody>
</table>
Additional Quality Measures

- Diabetes
- Cardiovascular disease
- Preventative care and Screening
- Pediatrics
- Geriatrics
- Appropriate use
- Asthma
- Oncology
- Alcohol and drug dependence
- Depression
- Ophthalmology
- HIV/AIDS
- Functional assessment
- Medication management
- Pregnancy
- Referral reports
Aligning CQMs Across Programs

• The same CQMs will be used in multiple quality reporting programs beginning in 2014
  – Other programs include Hospital IQR Program, PQRS, CHIPRA, and Medicare SSP and Pioneer ACOs
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What you can do to prepare

• Prepare for sharing information with patients:
  – Complete patients’ problem, medication and allergy lists. Make sure they are up to date and current
  – Decide what types of information you will share with patients
    • Patient portals will require a lot of decision making on the part of providers
  – Begin to encourage patients to get involved in their care
    • Talk up the fact that you will be adding technology to allow them to make appointments on line, message their provider and get their lab results
    • Help patients identify where they might access a computer (library, waiting room) and how to manage privacy in such a setting
  – Explore whether you will use your vendor’s portal solution or some other option

• Prepare for exchanging information with others:
  – Establish relationships with other organizations to which you refer in order to begin planning exchange (that can include nursing homes and home care)
  – Think about connecting with your cancer registry or some other national registry to submit data
What you can do to prepare

• Make sure your technology will be ready
  – Plan to undergo an EHR upgrade in late 2013 early 2014
  – Talk with your vendor about upgrade timelines
  – Look at the quality measures and let your vendor know which ones are important to you
  – For hospitals, prepare for bar-coded medication administration

• Plan for more decision support
  – Understand how your vendor will support having 5 “interventions” tied to relevant quality measures
  – Begin to think about the types of interventions you will incorporate into your EHR

• Reinforce the fact that we are doing this to achieve the “Triple Aim” of health care:
  – Improving the patient experience of care (including quality and satisfaction)
  – Improving the health of populations
  – Reducing the per capita cost of health care
Resources:

- Regional Extension Assistance Center for Health Information Technology (REACH)
  - [http://www.khaREACH.org](http://www.khaREACH.org)
- Stratis Health HIT Toolkits for hospitals, clinics, home health, nursing homes and chiropractic
- CMS Stage 2 web page (with Stage 2 specification sheets)
- CMS Meaningful Use Site:
  - [http://www.cms.gov/EHRIncentivePrograms/](http://www.cms.gov/EHRIncentivePrograms/)
- Office of the National Coordinator Health IT site:
  - [http://HealthIT.gov](http://HealthIT.gov)
- Certified EHRs and what modules they are certified for:
  - [http://healthit.hhs.gov/chpl](http://healthit.hhs.gov/chpl)
- CMS Stage 3
  - [http://www.healthit.gov/buzz-blog/meaningful-use/set-stage-meaningful-stage-3](http://www.healthit.gov/buzz-blog/meaningful-use/set-stage-meaningful-stage-3)
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