Meaningful Use Objectives Overview

Massachusetts Medicaid EHR Incentive Program

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Agenda

- Timeline
- Meaningful Use (MU) Objectives:
  1. Protect Patient Health Information (Security Risk Analysis)
  2. Clinical Decision Support (CDS)
  3. Computerized Provider Order Entry (CPOE)
  4. Electronic Prescribing (eRx)
  5. Health Information Exchange (HIE) – previously known as “Summary of Care”
  6. Patient-Specific Education
  7. Medication Reconciliation
  8. Patient Electronic Access (Patient Portal)
  9. Secure Electronic Messaging
  10. Public Health Reporting

Timeline

- For Program Year 2016:
  - CMS proposed rule for EHR reporting period:
    "Any continuous 90-day period within calendar year 2016"
  - Last possible reporting period: **October 3, 2016 - December 31, 2016**
  - Program Year 2016 is last year to initiate program participation

Looking ahead… MU Attestations Only

Program Year 2017	**Reporting period**
• First-time MU participants	Any continuous 90-day
• Modified Stage 2 participants	365-day
• Stage 3 participants (optional)	Any continuous 90-day
Program Year 2018	
• All participants	365-day

Objective 1: Protect Patient Health Information (PHI)

Protect electronic health information (PHI) created or maintained by CEHRT through implementation of appropriate technical capabilities

Measure

Conduct or review security risk analysis (SRA), including:

- Address security to include encryption of ePHI
- Implement security updates & correct identified security deficiencies as part of EP's risk management process (Mitigation plan)

No Exclusion

Meeting Objective 1: Protect PHI

Conduct or review annual Security Risk Analysis/Review (SRA/SRR)

- For all locations where EP practices

Cover all 5 key security areas

Physical Safeguards

Administrative Safeguards

Technical Safeguards

Policies & Procedures

Organizational Requirements

Create Mitigation Plan to address identified security deficiencies

- Assign responsibility for action steps
- Create timeline for completion of updates and corrections
- Document everything

Attesting to Objective 1: Protect PHI

Upload Supporting Documentation *

- SRA/SRR for each location
  where EP practices and utilizes CEHRT during EHR reporting period

  Include:
  - Name of practice
  - Location
  - Date completed
  - Signature of authorized official
  - Name and title of person who conducted SRA/SRR
  - Mitigation plan detailing action steps to correct/diminish identified security gaps

- Completed SRA/SRR cover sheet
  attesting to truthfulness and accuracy of analysis

* All Supporting documentation for all MU objectives must be uploaded into MAPIR

Objective 2: Clinical Decision Support (CDS)

Use clinical decision support (CDS) to improve performance on high-priority health conditions

Measure 1

Implement 5 CDS interventions related to 4 or more CQMs
for entire EHR reporting period

Measure 2

Enable and implement drug-drug & drug-allergy interaction checks
for entire EHR reporting period

Exclusion for Measure 2

Any EP who writes fewer than 100 medication orders
during EHR reporting period

Meeting Objective 2: CDS

Implement 5 CDS related to 4 CQMs

- CDS interventions are not limited to just alerts:
  - Variety of electronic workflow/process tools are allowed
- If none of the CQMs are in scope of practice:
  - Implement interventions that drive improvements in care delivery for relevant high-priority health conditions
- Organizations with multiple EPs can select:
  - Global CDS that are used across all specialties

+

Enable and implement drug-drug & drug-allergy interaction alerts

Attesting to Objective 2: CDS

Upload Supporting Documentation for Measure 1

- EHR-generated screenshots
  dated within EHR reporting period and identifying both EP and organization
- Documentation showing interventions relate to 4 or more CQMs
  related to the scope of practice, OR

  Letter from EP's Supervisor or Medical Director
  explaining CDS's relationship to patient population and high priority conditions

For global CDS implementations:

- Screenshot with practice name and enabled date*

  * If screenshots don't display enabled dates, submit either CEHRT audit logs with enabled dates, OR Vendor letter confirming enabled dates and that EPs are unable to deactivate interventions
- Letter on letterhead and signed by Medical Director
  confirming relevance to EP and with list of all EPs using the CDS

Upload Supporting Documentation for Measure 2

- Documentation from CEHRT identifying both EP & organization
  showing drug-drug & drug-allergy interaction checks for entire reporting period

Objective 3: Computerized Provider Order Entry (CPOE)

Use CPOE for medication, laboratory and radiology orders entered by licensed healthcare professional who can enter orders into medical record per state, local and professional guidelines

Measure 1 More than 60% of medication orders created during EHR reporting period recorded using CPOE

Measure 2 More than 30% of laboratory orders during…

Measure 3 More than 30% of radiology orders during…

Exclusions – Any EP who during EHR reporting period:

- Measure 1: writes fewer than 100 med orders
- Measure 2: writes fewer than 100 lab orders
- Measure 3: writes fewer than 100 radiology orders

Alternate exclusions for measures 2 and 3

- EPs scheduled to be in Stage 1 MU for 2016 may claim the exclusions

Meeting Objective 3: CPOE

Ensure EPs correctly and consistently utilize CPOE for all orders

- Medications, Consultations, Lab services, Imaging studies

Monitor MU dashboard to ensure data is captured for each EP

- During the EHR reporting period

Attesting to Objective 3: CPOE

- In MAPIR, enter the dashboard numerators/denominators to show EP meets threshold for each CPOE measure

Upload Supporting Documentation

- EHR generated dashboard / report with:
  - Selected MU period
  - EP's name
  - Numerator, Denominator, Percentage for each CPOE measure

Objective 4: Electronic Prescribing (eRx)

Generate and transmit permissible prescriptions electronically (eRx)

Measure

More than 50% of permissible prescriptions written are queried for drug formulary and transmitted electronically using CEHRT

Exclusions – Any EP who:

- Writes fewer than 100 prescriptions during EHR reporting period
- Has no pharmacy within organization and no pharmacies accepting eRx within 10 miles of EP's practice at start of reporting period

Meeting Objective 4: eRx

Electronically generate and transmit prescriptions

- Provider is permitted, but not required, to limit the measure to:
  - Patients whose records are maintained using CEHRT
- Denominator must include all prescriptions written by EP
  - whether electronic or on paper during EHR reporting period

Monitor MU dashboard to ensure data is captured for each EP

- During the EHR reporting period

Attesting to Objective 4: eRx

- In MAPIR, enter the dashboard numerator/denominator to show EP meets 50% eRx threshold

Upload Supporting Documentation

- EHR generated dashboard / report with:
  - Selected MU period
  - EP's name
  - Numerator, Denominator, Percentage for eRX measure

Objective 5: Health Information Exchange (HIE)

EP who transitions or refers their patient to another setting of care or another provider of care provides a summary care record for each transition of care or referral

Measure

(1) use CEHRT to create a summary of care record; and
(2) electronically transmit such summary to a receiving provider for more than 10% of transitions of care and referrals

Exclusion

Any EP who transfers patient to another setting or refers patient to another provider less than 100 times during EHR reporting period

Meeting Objective 5: HIE

Use Health Information Exchange to send Summary of Care records

- When patients are transferred during the EHR reporting period
- Exchange may occur before, during or after EHR reporting period
  but: no earlier than start of same calendar year
  and: no later than date of attestation
- Only patients whose records are maintained using CEHRT must be included in denominator for transitions of care

Monitor MU dashboard to ensure data is captured for each EP

- During the EHR reporting period

Attesting to Objective 5: HIE

- In MAPIR, enter the dashboard numerator/denominator to show EP meets10% HIE threshold

Upload Supporting Documentation

- EHR generated dashboard / report with:
  - Selected MU period
  - EP's name
  - Numerator, Denominator, Percentage for HIE measure

- Copy of one Summary of Care Record with EP's name
  - occurring before, during or after EHR reporting period, but no earlier than start of same calendar year and no later than date of attestation
  - At a minimum include Current problem list, Current medication list, Current medication allergy list
  - Must be in human readable format

Objective 6: Patient Specific Education

Use clinically relevant information from CEHRT to identify patient specific education resources and provide those resources to the patient

Measure

Patient specific education identified by CEHRT is provided to more than 10% of all unique patients with office visits seen in EHR reporting period

Exclusion

Any EP who has no office visits during EHR reporting period

Meeting Objective 6: Patient Specific Education

Use EHR-identified education resources

Provide the education resources to patients

Monitor MU dashboard to ensure data is captured for each EP

- During the EHR reporting period

Attesting to Objective 6: Patient Specific Education

- In MAPIR, enter the dashboard numerator/denominator to show EP meets 10% Patient Specific Education threshold

Upload Supporting Documentation

- EHR generated dashboard / report with:
  - Selected MU period
  - EP's name
  - Numerator, Denominator, Percentage for Patient Specific Education

Objective 7: Medication Reconciliation

EP who receives a patient from another setting of care or provider of care or believes an encounter is relevant performs a medication reconciliation

Measure

EP performs medication reconciliation for more than 50% of transitions of care in which the patient is transitioned into the care of the EP

Exclusion

Any EP who is not a recipient of any transitions of care during the EHR reporting period

Meeting Objective 7: Medication Reconciliation

Reconcile the medications after transitions of care

Monitor MU dashboard to ensure data is captured for each EP

- During the EHR reporting period

Attesting to Objective 7: Medication Reconciliation

- In MAPIR, enter the dashboard numerator/denominator to show EP meets the 50% Medication Reconciliation threshold

Upload Supporting Documentation

- EHR generated dashboard / report with:
  - Selected MU period
  - EP's name
  - Numerator, Denominator, Percentage for Medication Reconciliation

Objective 8: Patient Electronic Access

Provide patients the ability to view online, download and transmit their health information within 4 business days of info being available to EP

Measure 1

More than 50% of all unique patients seen during EHR reporting period are provided timely access to view online, download, and transmit their health information

Measure 2

At least one patient seen by EP during EHR reporting period views, downloads, or transmits their health information to third party during the EHR reporting period

Objective 8: Patient Electronic Access, continued

Exclusion Measure 1

- Any EP who neither orders nor creates any of the information listed for inclusion as part of the measure, except “Patient Name” or “Provider’s Name and Office Contact Information”

Exclusion Measure 2

- Any EP who neither orders nor creates any of the information listed for inclusion as part of the measure, except “Patient Name” or “Provider’s Name and Office Contact Information”
- More than half of the EP’s encounters are in an a county that does not have 50% or more of its housing units with 4Mbps broadband

Meeting Objective 8: Patient Electronic Access

Give patients ability to access records within 4 business days

Inform patients with instructions on how to access

Engage with patients to ensure at least one patient uses the access

Monitor MU dashboard to ensure data is captured for each EP

- During the EHR reporting period

Attesting to Objective 8: Patient Electronic Access

- In MAPIR, enter the dashboard numerator/denominator to show EP meets 50% Patient Electronic Access threshold

Upload Supporting Documentation for Measure 1

- EHR generated dashboard / report with:
  - Selected MU period
  - EP's name
  - Numerator, Denominator, Percentage for Patient Electronic Access measure 1

Upload Supporting Documentation for Measure 2

EHR-generated report showing at least 1 patient seen by EP during EHR reporting period viewed, downloaded, or transmitted their health info:

- no earlier than start of same calendar year as reporting period, and
- no later than the date of attestation

Objective 9: Secure Electronic Messaging

Use secure electronic messaging to communicate with patients on relevant health Information

Measure

A secure message was sent to at least one patient seen during EHR reporting period using the electronic messaging function of CEHRT to the patient, or in response to a secured message sent by a patient

Exclusion

Any EP who has no office visits during EHR reporting period, or more than half of EP's encounters are in an a county that does not have 50% or more of its housing units with 4Mbps broadband

Meeting Objective 9: Secure Electronic Messaging

Enable electronic messaging for the EHR reporting period

Electronic message can be

- **Email**
- **Electronic messaging function of PHR**
- **Online Patient Portal**
- **Any other electronic means**

Send at least one electronic message to patient

- Sending must occur within same calendar year as reporting period,
- but may be sent before, during or after EHR reporting period if that period is less than one full calendar year.

Make sure patient can send and receive secure electronic messages

Attesting to Objective 9: Secure Electronic Messaging

- In MAPIR, select “Yes/No” that electronic messaging capability was enabled for the EHR reporting period

Upload Supporting documentation

- Documentation that demonstrates secure messaging functionality had been enabled prior to or during the EHR reporting period

- EHR-generated report showing that for at least one patient seen during the EHR reporting period, a secure message was sent
  - using the electronic messaging function of CEHRT to the patient (or representative); or
  - in response to a secure message sent by the patient (or representative)

Objective 10: Public Health Reporting

EP is in active engagement with public health agency to submit electronic public health data from CEHRT

Measure 1

Immunization Registry: EP is in active engagement with a public health agency to submit immunization data

Measure 2

Syndromic Surveillance: Does not apply in Massachusetts

Measure 3

Specialized Registry: EP is in active engagement to submit data to a specialized registry

Objective 10: Public Health Reporting, continued

Exclusion Measure 1 – Immunization Registry

- EP does not administer any immunizations to any of the populations for which data is collected in the area

Massachusetts has MIIS registry, so the other two exclusions are not applicable

Exclusions Measure 2 – Syndromic surveillance

- MA Department of Public Health (DPH) does not accept syndromic surveillance data from EPs. All EPs in MA will take this exclusion.

Objective 10: Public Health Reporting, continued

Exclusions Measure 3 – Specialized Registry

- Any EP who does not diagnose or treat diseases or conditions associated with data required by specialized registry in the area

Massachusetts has cancer registry, so the other two exclusions are not applicable

Alternate Exclusions Measure 2 and 3

- All EPs may claim alternate exclusion for measure 2 and 3 for 2016

Meeting Objective 10: Public Health Reporting

Measure 1 – Immunization Registry

EP must register intent with MIIS, OR
demonstrate active engagement with MIIS

+

Measure 2 – Syndromic surveillance – Does not apply in MA

+

Measure 3 – Specialized Registry

EP must register with a specialized registry, OR
demonstrate active engagement with a specialized registry

Attesting to Objective 10: Public Health Reporting

Measure 1 – Immunization Registry

In MAPIR, select "Yes/No" to report active engagement with MIIS

Supporting Documentation	
Yes	No
MIIS immunization acknowledgement; or MIIS Registration of Intent; or MIIS scorecard EP	Submit letter on letterhead signed by EP attesting to accuracy of exclusion

Measure 2 – Syndromic surveillance – Take exclusion

Measure 3 – Specialized Registry

In MAPIR, select "Yes/No" to report active engagement

Upload Supporting Documentation

- Documentation from specialized registry showing active engagement

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