RESOURCE AND PATIENT MANAGEMENT SYSTEM

EHR Meaningful Use - Office Hours

Announcement and Agenda

September 18 & 20, 2012

Office of Information Technology (OIT)
Albuquerque, New Mexico

Table of Contents

1.0 General Information

1.1 Purpose of Training

This will be a presentation about achieving and maintaining Meaningful Use Stage 1 for 2011through 2013 for Eligible Professionals.

Training will review necessary steps to ensure EPs will receive maximum incentive payments possible for either the Medicaid or Medicare Incentive Program. There will be an overview presentation with a question/answer period. Following the presentation there will be RPMS EHR experts available to help assess and correct individual site challenges.

The "need" for this course was determined from (a) the need for an understanding of Meaningful requirements, reports, and maintenance; (b) requests from sites and providers; and (c) Meaningful Use and EHR deployment teams.

1.2 Prerequisites

If using a certified version of RPMS EHR, participants should run a MU Performance Measures Report prior to the course.

Knowledge, skills, and competencies recommended for this course include cognitive knowledge and competent utilization to include:

- Understanding the RPMS PCC and EHR architecture
- Delineating the expectations, roles, and responsibilities of Eligible Professionals and Eligible Hospitals concerning issues that surround the Certified RPMS EHR and Meaningful Use
- Experience navigating through RPMS EHR and its tabs
- Experience with running reports for maintaining a complete and accurate medical record

1.3 Guidelines for Receiving Continuing Education Credit

This program does not meet AAPC guidelines for CEUs.

2.0 Learning Objectives

See Detailed Agenda (Section 4.0).

3.0 Instructors and Facilitators

Disclosure Statement: In order to ensure balance, independence, objectivity, and scientific rigor in its educational activities, the (a) course directors/coordinators, (b) planning committee members, (c) faculty, and (d) all others who are in a position to control the content of this educational activity are required to disclose all relevant financial relationships with any commercial interest related to the subject matter of the educational activity. Safeguards against commercial bias have been put in place. Faculty will also disclose any off-label and/or investigational use of pharmaceuticals or instruments discussed in their presentation. The course directors/coordinators, planning committee members, and faculty for this activity have completed the disclosure process and have indicated that they do not have any significant financial relationships or affiliations with any manufacturers or commercial products to disclose.

3.1 Albuquerque, NM (OIT), New Mexico -

- David Taylor, MHS, RPh, PA-C,RN, OIT EHR Training & Deployment Manager
- Phil Taylor, BA, RN, Clinical Consultant, Medsphere Systems Corporation
- JoAnne Hawkins, Meaningful Use Senior Healthcare Policy Analyst, DNC (Contractor)
- Cecelia Rosales, Meaningful Use Requirements Manager, DNC (Contractor)
- Chris Lamer, Meaningful Use Federal Lead, PharmD, BCPS, CDE, MHS, OIT
- Luther Alexander, Meaningful Use Project Manager, DNC (Contractor)

4.0 Detailed Agenda

All times are Mountain Time!

Monday			
Start			
9/18	**9/20**	**Topic**	**TAB#**
9:00	1:00	Meaningful Use Stage 1 for EPs: Achieving MU and Reporting Requirements **JoAnne Hawkins, Cecelia Rosales** At the end of this session participants should be able to: • Understand CMS EHR Incentive Program • Understand the Meaningful Use Attestation requirements for Stage 1 • Understand the MU Deadlines for EPs reporting for CY/ 2012 • Understand the MU Reporting Period Requirements and Deadlines for EPs to begin to achieve MU for CY/FY 2013	TAB 1
10:30	2:30	RPMS Challenge Assessment and Correction – Open question and answer session for sites to ask questions about MU challenges they are experiencing. **David Taylor, Phil Taylor** At the end of this session participants should be able to: • Identify RPMS and Workflow issues affecting MU achievement • Identify solutions and/or resources for solution development • Understand corrective actions to be taken	
1:00	5:00	Adjourn	

5.0 ARRA, HITECH, and Meaningful Use

Background

On February 17, 2009, President Barack H. Obama signed the ARRA into law. ARRA provides incentives to encourage hospitals and office-based physicians to adopt EHRs and other health information technology (HIT) solutions that reduce costs by improving quality, safety, and efficiency. ARRA contains numerous technology and privacy provisions with aggressive timelines for completion. Many of these ARRA milestones relate to the standards and work of the Healthcare Information Technology Standards Panel.

Health Information Technology for Economic and Clinical Health Act

The Health Information Technology for Economic and Clinical Health Act (HITECH) is a focal point of ARRA and represents an investment of more than $19 billion towards healthcare information technology (IT)-related initiatives. The $19 billion dedicated to HITECH is divided into two portions: (a) $17 billion toward a Medicare/Medicaid incentive reimbursement program for both healthcare organizations and providers who can demonstrate "meaningful use" of an approved EHR; and (b) $2 billion available to providers located in qualifying rural areas, providers serving underserved urban communities, and providers serving underserved Indian tribes. Meaningful use of an approved EHR is required in order for providers to qualify for, and continue to receive, incentives.

Incentive Payments

ARRA will provide incentive payments through Medicare and Medicaid reimbursement systems to encourage providers and hospitals to adopt EHRs and HIT. Incentive payments are triggered when a provider or hospital demonstrates that it has become a "meaningful EHR user." The highest incentive payments will be granted to providers and hospitals that adopt EHR technology in the years 2011, 2012, or 2013. Reduced incentive payments are granted to hospitals that adopt EHR technology in the years 2014 or 2015, while no incentive payments are granted to hospitals that adopt EHR technology after 2015. Providers and hospitals that fail to meet this time limit will be subject to penalties in the form of reduced Medicare reimbursement payments beginning in 2017.

Meaningful Use

Meaningful use is a term used by the Centers for Medicare and Medicaid Services (CMS) to ensure that providers and hospitals that have adopted certified EHR are using the technology to further the goals of information exchange among health care professionals. EPs (eligible providers) and EHs (eligible hospitals) will achieve meaningful use if they: (a) demonstrate use of certified EHR technology in a meaningful manner, (b) demonstrate the certified EHR technology provides for electronic exchange of health information to improve quality of care, and (c) use certified EHR technology to submit information on clinical quality and other measures.

Achieving meaningful use will be accomplished in three stages. Stage 1 will begin in 2011, Stage 2 will begin in 2014, and Stage 3 will begin in 2016. The criteria for achieving meaningful use will increase with each stage and will build upon the prior stage. Medicare and/or Medicaid incentives are available to providers and hospitals who become meaningful users of certified EHR technology, with the maximum incentives being given to EPs and hospitals that become meaningful users in Stage 1. Hospitals may be eligible for both Medicare and Medicaid incentives but EPs must choose between the two incentive programs.

In order to achieve Meaningful Use, an EP must report on 15 core performance measures and 5 out of 10 menu set performance measures simultaneously. One of the EP's chosen menu set measures must be a designated Public Health Objective. Eligible hospitals must report on 14 core performance measures and 5 out of 10 menu set performance measures simultaneously. One of the selected menu set performance measures must be a designated Public Health Objective.

For demonstrating Meaningful Use through the Medicare EHR Incentive Program, the reporting period for the first year is any continuous 90-day period. In subsequent years, the EHR reporting period is the entire year. Under the Medicaid program, performance measures and incentive payments may be awarded for merely adopting, implementing or upgrading certified EHR technology. Consequently, there is no Medicaid reporting period for year one. The second Medicaid participation year reporting will be for any continuous 90-day period – all subsequent reporting periods are a full year. The exception for this will be that all reporting will be for any continuous 90-day period during the 2014 reporting year, when all hospitals and providers will be required to upgrade to a CHERT that meets the 2014 Edition EHR Certification Criteria, no matter which stage they are in.

Meaningful Use Standards and Measures

As required to achieve MU, eligible hospitals and EPs must report their performance on two types of measures:

- Performance Measures
- Clinical Quality Measures

The performance measures aim to improve quality, safety, efficiency and reduce health disparities. There are two types of performance measures: 1) Rate measures are numerically calculated with numerator and denominator data, 2) Attestation measures must be answered with a yes or no question.

Table 1: Summary Overview of Meaningful Use Core Set Measures

Short Name	Objective:	Measure:
Demographics	Record demographics: preferred language, gender, race and ethnicity, date of birth, and date of death and preliminary cause of death in the event of mortality in the eligible hospital or CAH.	More than 50% of all unique patients seen by the EP or admitted to the eligible hospitals or CAH's inpatient or emergency departments (POS 21 or 23) have demographics recorded as structured data. (*EPs, EHs & CAHs*)
Vital signs	Record and chart changes in the following vital signs: Height, weight and blood pressure and calculate and display body mass index (BMI) for ages 2 and over, plot and display growth charts for children 2-20 years, including BMI.	For more than 50% of all unique patients age 2 and over seen by the EP or admitted to eligible hospital's or CAH's inpatient or emergency departments (POS 21 or 23), height, weight, and blood pressure are recorded as structured data. (*EPs, EHs & CAHs*)
Problem List	Maintain up-to-date problem list of current and active diagnoses.	More than 80% of all unique patients seen by the EP or admitted to the eligible hospital's or CAH's inpatient or emergency departments (POS 21 or 23) have at least one entry or an indication that no problems are known for the patient recorded as structured data. (*EPs, EHs & CAHs*)
Medication List	Maintain active medication list.	More than 80% of all unique patients seen by the EP or admitted to the eligible hospital's or CAH's inpatient or emergency departments (POS 21 or 23) have at least one entry (or an indication that the patient is not currently prescribed any medication) recorded as structured data. (*EPs, EHs & CAHs*)
Medication Allergy List	Maintain active medication allergy list.	More than 80% of all unique patients seen by the EP or admitted to the eligible hospital's or CAH's inpatient or emergency departments (POS 21 or 23) have at least one entry (or an indication that the patient has no known medication allergies) recorded as structured data. (*EPs, EHs & CAHs*)

Short Name	Objective:	Measure:
Smoking Status	Record smoking status for patients age 13 or older.	More than 50% of all unique patients 13 years old or older seen by the EP or admitted to the eligible hospital's or CAH's inpatient or emergency departments (POS 21 or 23) have smoking status recorded as structured data. (*EPs, EHs & CAHs*)
Clinical Summaries	Provide clinical summaries for patients for each office visit.	Clinical summaries provided to patients for more than 50% of all office visits within 3 business days. (*EPs Only*)
Electronic Copy of Health Information	Provide patients with an electronic copy of their health information (including diagnostic test results, problem list, medication lists, medication allergies, discharge summary, procedures) upon request.	More than 50% of all patients seen by the EP or of the eligible hospital's or CAH's inpatient or emergency departments (POS 21 or 23) who request an electronic copy of their health information are provided it within 3 business days. (*EPs, EHs & CAHs*)
ePrescribing	Generate and transmit permissible prescriptions electronically.	More than 40% of all permissible prescriptions written by the EP are transmitted electronically using certified EHR technology. (*EPs Only*)
CPOE Medication	Use CPOE for medication orders directly entered by any licensed healthcare professional who can enter orders into the medical record per state, local and professional guidelines.	More than 30% of all unique patients with at least one medication in their medication list seen by the EP or admitted to the eligible hospital's or CAH's inpatient or emergency departments (POS 21 or 23) during the EHR reporting period have at least one medication order entered using CPOE. NOTE: In Stage 2, the measure target increases to 60%. (*EPs, EHs & CAHs*)
Drug-Drug & Drug-Allergy Checks	Implement drug-drug and drug-allergy interaction checks.	Functionality is enabled for these checks for the entire reporting period. (*EPs, EHs & CAHs*)

Short Name	Objective:	Measure:
Clinical Decision Support	For EPs, implement one clinical decision support rule relevant to specialty or high clinical priority. For eligible hospital or CAH implement one related to a high priority hospital condition along with the ability to track compliance with that rule.	Implement one clinical decision support rule. (*EPs, EHs & CAHs*)
Privacy/Security	Protect electronic health information created or maintained by the certified EHR technology through the implementation of appropriate technical capabilities.	Conduct or review a security risk analysis per 45 CFR 164.308 (a)(1) of the certified EHR technology, and implement security updates and correct identified security deficiencies as part of its risk management process. (*EPs, EHs & CAHs*)
CQM	Report ambulatory and hospital clinical quality measures to CMS or, in the case of Medicaid, to the States.	Successfully report to CMS (or, in the case of Medicaid, to the States) ambulatory and hospital clinical quality measures selected by CMS in the manner specified by. (*EPs, EHs & CAHs*)
Exchange of Key Clinical Information	Capability to exchange key clinical information (for example, discharge summary, procedures, problem list, medication list, medication allergies, diagnostic test results), among providers of care and patient's authorized entities electronically.	Performed at least one test of certified EHR technology's capacity to electronically exchange key clinical information. (*EPs, EHs & CAHs*)
Electronic Copy of Discharge Instructions	Provide patients with an electronic copy of their discharge instructions at the time of discharge, upon request.	More than 50% of all patients who are discharged from an eligible hospital's or CAH's inpatient or emergency departments (POS 21 or 23) and who request an electronic copy of their discharge instructions are provided it. (*Hospitals Only*)

Table 2: Summary Overview of Menu Set Meaningful Use Measures

Short Name	Objective:	Measure:
Drug-Formulary Checks	Implement drug formulary checks.	The EP, eligible hospital/CAH has enabled this functionality and has access to at least one internal or external formulary for the entire EHR reporting period. (*EPs, EHs & CAHs*)

Short Name	Objective:	Measure:
Lab Results into EHR	Incorporate clinical laboratory test results in EHRs as structured data.	More than 40% of all clinical lab test results ordered by an EP or authorized provider of the eligible hospital or CAH for patients admitted to its inpatient or emergency departments (POS 21 or 23) during the EHR reporting period whose results are either in a positive/negative or numerical format are incorporated in certified EHR technology as structured data. (*EPs, EHs & CAHs*)
Patient List	Generate lists of patients by specific conditions to use for quality improvement, reduction of disparities, research, or outreach.	Generate at least one report listing patients of the EP, eligible hospital or CAH with a specific condition. (*EPs, EHs & CAHs*)
Patient-Specific Education	Use EHR technology to identify patient-specific education resources and provide those to the patient as appropriate.	More than 10% of all unique patients seen by the EP or admitted to the eligible hospital's or CAH's inpatient or emergency departments (POS 21 or 23) are provided patient-specific education resources. (*EPs, EHs & CAHs*)
Medication Reconciliation	The EP, EH or CAH who receives a patient from another setting of care or provider of care or believes an encounter is relevant should perform medication reconciliation.	The EP, eligible hospital or CAH performs medication reconciliation for more than 50% of transitions of care in which the patient is transitioned into the care of the EP or admitted to the eligible hospital's or CAH's inpatient or emergency departments (POS 21 or 23). *EPs, EHs & CAHs*)
Summary of Care	The EP who transitions their patient to another setting of care or provider of care or refers their patient to another provider of care should provide summary of care record for each transition of care or referral.	The EP, EH or CAH that transitions or refers their patient to another setting of care or provider of care provides a summary of care record for more than 50% of transitions of care and referrals. (*EPs, EHs & CAHs*)

Short Name	Objective:	Measure:
Advance Directives	Record advance directives for patients 65 years old or older.	More than 50% of all unique patients 65 years old or older admitted to the eligible hospital's or CAH's inpatient department (POS 21) have an indication of an advance directive status recorded as structured data. (*Hospitals Only*)
*Immunization Registries	Capability to submit electronic data to immunization registries or Immunization Information Systems and actual submission in accordance with applicable law and practice.	Performed at least one test of certified EHR technology's capacity to submit electronic data to immunization registries and follow-up submission if the test is successful (unless none of the immunization registries to which the EP, EH or CAH submits such information have the capacity to receive the information electronically.) (*EPs, EHs & CAHs*)
Patient Reminders	Send reminders to patients per patient preference for preventive/follow-up care.	More than 20% of all unique patients 65 years old or older or 5 years old or younger were sent an appropriate reminder during the EHR reporting period. (*EPs Only*)
Timely Electronic Access to Health Information	Provide patients with timely electronic access to their health information (including lab results, problem list, medication lists, medication allergies) within four (4) business days of the information being available to the EP.	At least 10% of all unique patients seen by the EP are provided timely (available to the patient within four (4) business days of being updated in the certified EHR technology) electronic access to their health information subject to the EP's discretion to withhold certain information. (*EPs Only*)
*Submit Lab Results to Public Health Agencies	Capability to submit electronic data on reportable (as required by state or local law) lab results to public health agencies and actual submission in accordance with applicable law and practice.	Performed at least one test of certified EHR technology's capacity to provide electronic submission of reportable lab results to public health agencies and follow-up submission if the test is successful (unless none of the public health agencies to which eligible hospital or CAH submits such information have the capacity to receive the information electronically.) (*Hospitals Only*)

Short Name	Objective:	Measure:
*Syndromic Surveillance	Capability to submit electronic syndromic surveillance data to public health agencies and actual submission in accordance with applicable law and practice.	Perform at least one test of certified EHR technology's capacity to provide electronic syndromic surveillance data to public health agencies and follow-up submission if the test is successful (unless none of the public health agencies to which EP, EH or CAH submits such information have the capacity to receive the information electronically.). (*EPs, EHs & CAHs*)
* All EPs, EHs and CAHs must choose at least one of these populations and public health measures to demonstrate as part of the menu sets.		

6.0 Biographical Sketches

The Indian Health Service (IHS) Office of Information Technology (OIT) National Electronic Health Record (EHR) Training and Deployment Program and Meaningful Use (MU) Team worked diligently to prepare the necessary training documents to facilitate the achievement of Meaningful Use (MU) of an EHR. We hope that you find both the training and training documents helpful.

The Office of Information Technology conveys its sincere thanks to all the members and guests of this workgroup. They spent long hours preparing and updating these documents and even longer documenting their experience; they deserve our appreciation. Without these dedicated workgroup members this "EHR Meaningful Use" Office Hours would not be possible.

Luther Alexander, PMP, Meaningful Use Project Manager
DNC Contractor

Currently serves as a contractor with Data Network Corporation. Luther is Project Manager for Meaningful Use and Certification for the Indian Health Service. Previously Luther served as the American Recovery & Reinvestment Act Program Manager for IHS and later as CIO support Lead for Finance and Budget formulation and execution; he has been with IHS since 2008. Luther has over 15 years of Project Management experience working with various Federal Government Agencies ranging from DoD Intelligence to U.S. Department of Agriculture.

JoAnne Hawkins, Meaningful Use Sr. Healthcare Policy Analyst
DNC Contractor

Currently serves as a contractor with Data Network Corporations. JoAnne is the Sr. Healthcare Policy Analyst for Meaningful Use. Previously she served as Team Lead for 15 Meaningful Use Field Consultants. She has over 15 years of training experience in various industries including healthcare. Her focus is to help Indian Country achieve Meaningful Use.

Christopher Lamer, PharmD, MHS, BCPS, CDE

CDR Christopher Lamer is a Commissioned Officer in the United States Public Health Service and has been in the Indian Health Service since 1998. CDR Lamer is a pharmacist and works as a clinical informaticist for the Office of Information Technology and Health Education programs. CDR Lamer is highly involved the development of clinical programs, quality metrics, and support of RPMS applications.

Cecelia Rosales, Meaningful Use Requirements Manager
DNC Contractor

Currently serves as a contractor with Data Network Corporations. Cecelia is the Meaningful Use Requirements Manager. Previously she served as Lead for the National Meaningful Use Team. She brings 35 years of training experience for both government and corporate audiences, including 20 years U.S. Naval Medical

Administration experience. Her prior work experience includes assisting with upgrades to the NM Department of Health Immunization Registry and helping design medical studies and testing spine curvature calculation software at PhDx Systems, Inc. Cecelia is a retired Navy Hospital Corpsman, has a Bachelor's of Humanities in Communications from the Pennsylvania State University and works in the Albuquerque office.

CAPT (ret) David R. Taylor, MHS, RPh, PA-C, RN, NCPS
EHR Training and Deployment Manager
IHS Office of Information Technology

CAPT (ret) David Taylor is a retired Commissioned Officer in the United States Public Health Service and is a certified physician assistant, registered pharmacist, and registered nurse. Captain (ret) Taylor holds more than 33 years of public health, clinical, and clinic-administrative experience in the Indian Health Service (IHS). During his commission, he has served as a pharmacist, physician assistant, quality manger, risk manager, and compliance officer for the Pine Ridge, South Dakota and Cherokee, North Carolina Indian Hospitals. He has also served as an HIV/AIDS/STD consultant, performance improvement consultant, pharmacy consultant, and diabetes clinical consultant for the Nashville Area Indian Health Service. At this time, he is the EHR Deployment Manager for the IHS Office of Information Technology and has been charged with both training and deployment of the Electronic Health Record throughout the entire Indian Health Care system. David Taylor has been awarded the PHS Meritorious Service Medal (MSM) in recognition for his accomplishments in the EHR arena.

Phil Taylor, BA, RN
Clinical Application Specialist, Medsphere Corporation

Phil is a Clinical Consultant for Medsphere Systems Corporation. Phil has been a Registered Nurse for 34 years. He holds a degree in Nursing from Vincennes University and a B.A. in Classical Studies from Indiana University. Phil practiced as a staff nurse or nurse manager in Psychiatry for over 15 years. Phil provided clinical application support to VA Medical center staff in Indianapolis using the VistA electronic medical record system for over 12 years prior to joining Medsphere. Since joining Medsphere, Phil has worked with the national IHS deployment team for the past 5 years providing training support (such as Basic CAC School and EHR for Inpatient) and configuration/setup support to RPMS-EHR installations.