

Meaningful Use Stage 1:

Meeting the Measures, Complying with HIPAA, and Meeting the needs of your Patient.

There is a Difference!



Janine B. Akers

Resources and References

https://www.cms.gov/EHRIncentivePrograms/30_Meaningful_Use.asp

EHR Incentive Programs	Meaningful Use
<ul style="list-style-type: none"> » Overview » Path to Payment » Eligibility » Registration and Attestation » Certified EHR Technology » Meaningful Use » Medicare and Medicaid EHR Incentive Program Basics » Medicaid State Information » Medicare Advantage » Spotlight and Upcoming Events » Educational Materials » EHR Incentive Program Regulations and Notices » CMS EHR Incentive Programs Listserv » Frequently Asked Questions (FAQs) 	<p>The Medicare and Medicaid EHR Incentive Programs provide a financial incentive for th achieve health and efficiency goals. By putting into action and meaningfully using an EH financial incentives—such as reduction in errors, availability of records and data, remind; prescribing/refill automation.</p> <p>Click on the links below to learn more:</p> <ul style="list-style-type: none"> • What is "Meaningful Use": • What are the Criteria for Meaningful Use: • How do I Meet Meaningful Use Requirements: • What are the requirements for Stage 1 of Meaningful Use (2011 and 2012): • What are "Clinical Quality Measures": • What can I Learn from Meaningful Use Objectives Specification Sheets: • Downloads, related links: <p>What is "Meaningful Use"? The American Recovery and Reinvestment Act of 2009 specifies three main components</p> <ol style="list-style-type: none"> 1. The use of a certified EHR in a meaningful manner, such as e-prescribing. 2. The use of certified EHR technology for electronic exchange of health information 3. The use of certified EHR technology to submit clinical quality and other measure

Resources and References



Eligible Professional Meaningful Use Core Measures Measure 14 of 15

Stage 1
Date Issued: November 7, 2010

Electronic Exchange of Clinical Information	
Objective	Capability to exchange key clinical information (for example, problem list, medication list, medication allergies, and diagnostic test results), among providers of care and patient authorized entities electronically.
Measure	Performed at least one test of certified EHR technology's capacity to electronically exchange key clinical information.
Exclusion	No exclusion.

Resources and References

<http://edocket.access.gpo.gov/2010/pdf/2010-17210.pdf>



Federal Register

Wednesday,
July 28, 2010

Part III

Department of
Health and Human
Services

Resources and References

stated that adding formulary checks to the workload of physicians will decrease physicians' efficiency and increase their costs.

Comment. A commenter recommended that "drug-test checks" should be added. The commenter stated that many drugs require some form of

at the time of certification or at present time. Section 170.302(b)—Maintain Up-To-Date Problem List

Meaningful use stage 1 objective	Meaningful use stage 1 measure	Certification criterion
Maintain an 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 department (POS 21 or 23) have at least one entry or an indication that no problems are known for the patient recorded as structured data.	Interim Final Rule Text: <i>Maintain up-to-date problem list.</i> Enable a user to electronically record, modify, and retrieve a patient's problem list for longitudinal care in accordance with: (1) The standard specified in § 170.205(a)(2)(i)(A); or (2) At a minimum, the version of the standard specified in § 170.205(a)(2)(i)(B). Final Rule Text: § 170.302(c). Final rule text remains the same as Interim Final Rule text, except for references to adopted standards, which have been changed.

Comments. Several commenters expressed concerns about the use of ICD-9-CM because it is primarily used for billing and administrative purposes and may not accurately represent the true clinical meaning of a problem or

Comments. Several commenters recommended that only SNOMED-CT® be adopted, or alternatively, that we expressly indicate an intention to move away from ICD-9CM and ICD-10 in the future. Another commenter

eventually be able to adopt only one standard.
Comments. A few commenters asked for clarification as to whether SNOMED-CT® or ICD-9CM codes needed to be included within Certified

	Core Measure 12 of 15 Electronic Copy of Health Information	Core Measure 13 of 15 Clinical Summaries	Menu Set Measure 5 of 10 Patient Electronic Access
Objective	<ul style="list-style-type: none"> Provide patients with an electronic copy of their health information (including diagnostic test results, problem list, medication lists, medication allergies) upon request. 	<ul style="list-style-type: none"> Provide clinical summaries for patients for each office visit. 	<ul style="list-style-type: none"> Provide patients with timely electronic access to their health information (including lab results, problem list, medication lists, and allergies) within 4 business days of the information being available to the EP.
Measure	<ul style="list-style-type: none"> More than 50 percent of all patients who request an electronic copy of their health information are provided it within 3 business days. 	<ul style="list-style-type: none"> Clinical summaries provided to patients for more than 50 percent of all office visits within 3 business days. 	<ul style="list-style-type: none"> At least 10% of all unique patients seen by the EP are provided timely (available to the patient within 4business 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.
Exclusion	<ul style="list-style-type: none"> Any EP that has no requests from patients or their agents for an electronic copy of patient health information during the EHR reporting period. 	<ul style="list-style-type: none"> Any EP who has no office visits during the EHR reporting period. 	<ul style="list-style-type: none"> Any EP that neither orders nor creates lab tests or information that would be contained in the problem list, medication list, medication allergy list (or other information as listed at 45 CFR 170.304(g)) during the EHR reporting period.


	Core Measure 14 of 15 Electronic Exchange of Clinical Information	Core Measure 15 of 15 Risk Assessment
Objective	<ul style="list-style-type: none"> Capability to exchange key clinical information (for example, problem list, medication list, medication allergies, and diagnostic test results), among providers of care and patient authorized entities electronically. 	<ul style="list-style-type: none"> Protect electronic health information created or maintained by the certified HER technology through the implementation of appropriate technical capabilities.
Measure	<ul style="list-style-type: none"> Performed at least one test of certified EHR technology's capacity to electronically exchange key clinical information. 	<ul style="list-style-type: none"> Conduct or review a security risk analysis in accordance with the requirements under 45 CFR 164.308 (a)(1) and implement security updates as necessary and correct identified security deficiencies as part of its risk management process.
Exclusion	<ul style="list-style-type: none"> No Exclusion 	<ul style="list-style-type: none"> No Exclusion

Core Measure 15






- 1** Conduct a Security Risk Analysis
- 2** Identify Security Deficiencies
- 3** Implement Security Updates

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Assessment Methodology






Technology

-  Study and Situation Analysis
-  Individual Rule Review
-  Risk and Security Deficiencies Identification
-  Data Analysis
-  Report and Briefing

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Your Options to meet Measure 15

-  • NO Cost - Do it Yourself – See OCR and CMS for Regulations
-  • Web Based Questionnaire - Online, self navigated, utility
-  • Full Service Assessment with Recommendations

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Core Measure 14 – Data Exchange

**Core Measure
14 of 15
Electronic Exchange of Clinical
Information**

From EHR Incentive Program

*When the clinical information is available in a structured format it should be transferred in a structured format. However, if the information is unavailable in a structured format, the transmission of unstructured data is permissible.

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“Doesn’t have to be through an organized HIE activity. Doesn’t have to be structured data. Doesn’t have to be transported electronically, since ONC somehow decided not to create any standards for that. Doesn’t even have to be successfully uploaded by the receiving practice! It’s like testing my high school son’s ability to show up for the SAT exam on time and with a number 2 pencil, rather than his ability to actually answer the questions on the test. (He’d be thrilled!) “

	<p>Core Measure 12 of 15 Electronic Copy of Health Information</p>	<p>Core Measure 13 of 15 Clinical Summaries</p>	<p>Menu Set Measure 5 of 10 Patient Electronic Access</p>
Objective	<ul style="list-style-type: none"> Provide patients with an electronic copy of their clinical information (including lab results, diagnosis, medication, and medical history) upon request. 	<ul style="list-style-type: none"> Provide clinical summaries for patients upon request. 	<ul style="list-style-type: none"> Provide timely electronic access to their clinical information (including lab results, medication lists, and allergies) within 4 business days for Non Computer Patient.
Measure	<ul style="list-style-type: none"> Patients who request an electronic copy of their health information are provided within 30 days. Patient is moving Patient has not been seen in 2 years. They send in a form 	<ul style="list-style-type: none"> Clinical summaries are provided to patients for more than 90 percent of all office visits within 30 business days. 	<ul style="list-style-type: none"> At least 90 percent of patients are able to access their clinical information within 4 business days of request. Portal is Down Patient in Collections Dismissed Patient
Exclusion	<ul style="list-style-type: none"> Any EP that has no requests from patients or their agents for an electronic copy of patient health information during the EHR reporting period. 	<ul style="list-style-type: none"> Any EP who has no office visits during the EHR reporting period. 	<ul style="list-style-type: none"> Any EP that neither orders nor creates lab tests or information that would be contained in the problem list, medication list, medication allergy list (or other information as listed at 45 CFR 170.304(g)) during the EHR reporting period.

	Core Measure 14 of 15 Electronic Exchange of Clinical Information	Core Measure 15 of 15 Risk Assessment
Objective	<ul style="list-style-type: none"> • Capability to exchange key clinical information (for example, problem list, medication list, medication allergies, and diagnostic test results), among providers of care and patient authorized entities electronically. 	<ul style="list-style-type: none"> • Protect electronic health information created or maintained by the certified HER technology through the implementation of appropriate technical capabilities.
Measure	<ul style="list-style-type: none"> • Performed at least one test of certified EHR technology's capacity to electronically exchange key clinical information. 	<ul style="list-style-type: none"> • Conduct or review a security risk analysis in accordance with the requirements under 45 CFR 164.308 (a)(1) and implement security updates as necessary and correct identified security deficiencies as part of its risk management process.
Exclusion	<ul style="list-style-type: none"> • No Exclusion 	<ul style="list-style-type: none"> • No Exclusion

Thank You!



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