Participants today should leave with:

- A general overview of the goals of the Electronic Health Record (EHR) Incentive Program.

- An understanding of Clinical Decision Support (CDS) as it applies to the EHR Meaningful Use (MU) Program and how it can be applied in real time to many other quality initiatives.

- A vision of how transitions of care information will flow provider-to-provider electronically in future.
What is an EHR?

- An electronic health record (EHR)—sometimes called an electronic medical record (EMR)—allows healthcare providers to record patient information electronically instead of using paper records.
- However, EHRs are often capable of doing much more than just recording information.

What is the EHR Incentive Program?

- The Health Information Technology for Economic and Clinical Health Act (HITECH) 2009 – support the adoption & use of certified EHR records by providing financial incentives.
- To get an Incentive payment, Eligible Professionals (EPs) must use an EHR that is certified specifically for the EHR Incentive program. The Certified EHR Technology (CEHRT) will allow EPs to accomplish specific objectives.
Meaningful Use (MU)

• The overarching goal of the Health Information Technology for Economic and Clinical Health Act (HITECH) is not the mere adoption of new technology, but the use of electronic health records (EHR) to systematically improve healthcare access, delivery, and quality.

• Being a meaningful user indicates successful achievement of specific procedural and clinical benchmarks using certified EHR technology.

Individual Provider Participation Required

• Incentive payments are made to individual providers, not to practices or medical groups.

• Meaningful use attestations are based upon data produced by an individual provider and should reflect that individual provider’s scope of practice.
Stage 1 Data

- Data captured
  - Problem list
  - Medication & medication allergy list
  - Demographics
  - Vital signs
  - Smoking status
- Data shared
  - e-Prescribing
  - Immunization Registry records with TDOH
  - Patient electronic access to their health information
  - Clinical Summaries for each office visit
  - Transitions of Care (TOC) summary of care record exchanges
- Electronic Function
  - Computerized Provider Order Entry - medications (CPOE)
  - Clinical Decision Support (CDS) - 1
  - Patient listings
  - Medication Reconciliation when on receiving end of TOC
  - Drug-Drug interaction check
  - Drug Formulary Check
- Security Risk Assessment
- Clinical Quality Measures
Unique Stage 1 EPs by County/Region

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# Stage 1 EPs

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Unique Stage 1 EPs by County/Region

# of Counties by Region with Zero Stage 1 EPs

- West
- Middle
- East

# Counties with zero stage 1 EPs

Additional Stage 2 Data

Includes all Stage 1 data capabilities plus the following:

- Computer Provider Order Entry (CPOE) for radiology & lab tests
- Five Clinical Decision Support points must be deployed
- Threshold for patients who use the online access
- Incorporate lab results as structured data
- The clinically relevant information to identify patients who should receive reminders for preventive/follow-up care and send per patient preference
- Send Transitions Of Care (TOC) summary documents electronically to other providers
- Use secure messaging to communicate with patients
- Record electronic notes in patient records
- Access imaging results through CEHRT
- Report to other registries such as Cancer Registry
- New Clinical Quality Measures starting in 2014
### Stage 2 Eligible Professionals

#### TennCare Stage 2 EPs

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### Stage 2 EPs by County

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**EP Progression from AIU to MU**

**TennCare AIU to MU Progression**

- **AIU**
  - 3973
- **MU**
  - 1495

**Current EP Payments 8/24/2015**

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Future of EHR/MU program

- Reached the halfway mark in 2015 – incentives end in 2021.
- Outreach to providers who have attested to AIU but not MU. Quality Oversight has added a MU Clinical Educator to our staff who will be dedicated to working with TennCare providers trying to meet MU.
- Calendar year 2016 is the last year providers can begin participation in the EHR program.
- Providers that can use their certified EHR and demonstrate meaningful use of their EHR can positively affect the care of their patients.

So why should providers become meaningful users?

- Skills providers learn can help them meet other quality program requirements.
  - Clinical Decision Support is the success story of Stage 1 MU.
  - Transitions of Care can be the success story of Stage 2 MU.
- Ultimately the skills learned can:
  - Increase the quality of care they provide,
  - enhance health outcomes,
  - help to avoid errors and adverse events,
  - improve efficiency,
  - reduce cost,
  - boost provider and patient satisfaction.
Clinical Decision Support

- The clinical decision support is not meant to make clinical decisions or change a clinical decision made by a provider.
- It can be thought of as a way to enhance or facilitate the provider’s ability to make those clinical judgements and document them at the same time.
- The time a patient spends with a provider is limited. CDS that is planned and implemented well can make the provider’s work flow more efficient.
- CDS available for providers varies per EHR vendors. A wide range of CDS is currently being supported by EHRs your providers use every day.

5 Rights Framework for CDS Implementation

- The right information (e.g., evidence-based guidance, response to a clinical need);
- To the right people (entire care team – including the patient);
- Through the right channels (e.g., EHR, mobile device, patient portal);
- In the right intervention formats (e.g., order sets, flow-sheets, dashboards, patient lists);
- At the right points in workflow for optimized decision making or action.
CDS is Not Simply an Alert

- CDS encompasses a wide variety of tools including, but not limited to:
  - Computerized alerts and reminders for providers and patients
  - Focused patient data reports and summaries
  - Contextually relevant reference information
  - Actionable clinical guidelines
  - Condition-specific order sets
  - Documentation templates
  - Diagnostic support

CDS Order Set Example
MCO Role

- MCO or Health Plans constantly monitor the quality of the providers in their networks.

- MCO XYZ has identified 3 providers with either quality gaps or clinical guideline gaps.
  - Provider 1 is not performing or documenting age-appropriate preventive measures such as adolescent depression screening & HPV vaccination.
  - Provider 2 has an identified HEDIS gap related to BMI, nutritional and physical activity documentation in their medical records/claims.
  - Provider 3 has several diabetes gaps in care in his/her patient population.

- How can a provider’s certified EHR help?

CDS Example  Provider 1

- PCP1 activates a CDS in his/her EHR related to age-appropriate preventive services.
- Upon opening an adolescent patient’s electronic record during a patient visit, the PCP1 is informed of a recommendation to conduct an age-appropriate depression screen and to discuss HPV vaccination.
  - PCP1 selects the appropriate screening assessment tool and conducts the depression screen during the current encounter.
  - The screen results in a positive finding.
  - PCP1 gets a shared care plan tool prompt and an option to order a referral to a mental health provider.
  - If the adolescent has not had the HPV, it can also be prompted and offered during the encounter. If given, it is already documented in the record of the visit.
Example Provider 1

- PCP1 elected to facilitate age-appropriate depression screening and to monitor progress by selecting:
  - NQF 0418 – Preventive care and screening for clinical depression and follow-up plan to follow their progress.
- The EHR will collect the necessary data for NQF 0418 over time.
- PCP1 can routinely query the EHR for the numerator and denominator of NQF 0418 to assess their progress to see if improvement has been made.

Example Provider 1

- All providers with 2014 Edition CEHRT have the ability to use clinically relevant information stored in their EHR to identify patients who should receive reminders for preventive or follow-up care.
- PCP1 wants to work on getting adolescents in for a well visit & uses the EHR to send reminders by phone, mail, secure messaging, etc. to this population to remind them to come for a well visit.
- More than one CDS intervention can occur during an encounter. The depression screen can be completed, but other age appropriate reminders can be alerted.
- When the adolescent comes to the office for a visit, an HPV alert can show if there is no record of this vaccination in the EHR. The provider can then discuss HPV with the patient.
Example Provider 1 Outcomes

✓ The patients get the recommended care and referral if necessary and it is all documented in the EHR.
✓ A protocol for positive depression screens is automatic and documented.
✓ The care plan is documented. The provider can choose to treat the patient or to refer the patient to a behavioral health professional. The CDS does not make the decision but supports the clinical decision.
✓ The provider can follow real time progress made in meeting recommended care.
✓ If improvement is made, it is documented with the clinical quality measure.

CDS Example Provider 2

• PCP2 works with the vendor of their EHR to activate a CDS rule related to BMI, nutritional, & physical activity counseling.
• Upon opening a child’s electronic record during a patient visit, PCP2 is prompted to record BMI and to discuss appropriate nutrition and physical activity.
• If the BMI exceeds a limit set by PCP2, an additional intervention can be prompted and recorded in the record.
• The patient receives the recommended care, which is automatically documented electronically in their record.
Example Provider 2

- PCP2 has also selected a clinical quality measure to follow progress on the CDS. This provider selects NQF 0024 – Weight assessment and counseling for nutrition & physical activity for children & adolescents. The EHR of PCP2 will collect the information over time and produce numerators and denominators for the measure when queried.
- Documentation in the electronic medical record and collection of the clinical quality measure numerator and denominator can affect the HEDIS measurement for the provider for the current measurement period.

CDS Example Provider 3

- PCP3 works with the EHR vendor to activate a host of Diabetes recommended guidelines as CDS.
- Upon opening an adult patient’s electronic record during a patient visit, PCP3 can see a history of A1c and blood glucose results. If the most current result was collected more than three months prior to the current visit, the A1c and blood glucose results are displayed in red.
- PCP3 then orders an A1c and/or blood glucose test. The EHR can then at the appropriate time, send a message to the patient (via the format the patient requested) reminding them of the lab tests and fasting instructions.
Example Provider 3

- During the same visit, the EHR can show an alert for any diabetes recommended care that has not been completed.

- Foot exams, dilated eye exams, LDL screening, urine screening for protein or even blood pressure alerts can facilitate PCP3 in closing gaps.

- When the appropriate testing is complete, the results can be added as structured data within the EHR. The EHR can identify out of range results and send an alert to PCP3 in order to follow up.

Example Provider 3

- PCP3 worked with the EHR vendor to select the following clinical quality measures to follow over time:
  - NQF 0055 – Diabetes eye exam
  - NQF 0056 – Diabetes foot exam
  - NQF 0059 – Hemoglobin A1c poor control (>9%)
  - NQF 0062 – Diabetes Urine protein screening
  - NQF 0018 – Controlling high blood pressure (<140mmHg/90mmHg)

- The EHR does the work necessary to collect the appropriate data to calculate numerators and denominators for the clinical quality measures over time.
CDS and Meaningful Use 2015

Proposed Measure:
- Use clinical decision support to improve performance on high-priority health conditions.
- It would be left to the provider’s clinical discretion to select the most appropriate CDS interventions for his/her patient population.
- CDS interventions selected should be related to four or more of the clinical quality measures on which the provider would be expected to report.
- The goal of this objective is for providers to implement improvements in clinical performance for high-priority health conditions that would result in improved patient outcomes.
- CMS further adds, providers must implement the CDS intervention at a relevant point in the patient care when the intervention can influence clinical decision making before an action is taken on behalf of the patient.

Peer Counseling/Closing Identified Gaps in Care

When talking to providers about implementation of appropriate clinical care guidelines or closing gaps in care, the conversation should include:

✔ Do you use a certified EHR technology appropriate for Meaningful Use?
✔ What CDS does your CEHRT support currently?
✔ What CDS is available via your current CEHRT?
✔ Have you thought about making changes in your CDS to facilitate your.....?
CDS and Care Coordination Using CEHRT

CDS Examples from TennCare Stage 1 EPs

- **Pregnancy Precaution:** This clinical decision rule alerts the providers when they attempt to prescribe a medication to anyone of child bearing age that the medication might be harmful to the unborn child. Information provided to the prescriber includes severity of potential interaction, clinical effects, predisposing factors, patient management information and discussion notes.
- Include patients **18 and under** when a medication is chosen for prescribing (the provider is prompted with correct dosing).
- **Diabetic Order set** prompted when diabetic medication added or prescribed.
- Our clinic uses the CDS rule to notify providers and staff of sexually active patients requiring HIV testing on an annual basis.
- Include all female patients who are pregnant with blood type of RH Negative (prompts provider to order Rhogam injection).
- **Adult Flu** - To identify all adult patients in the target group, **over age 64** that have not had an influenza immunization during the current flu season. Used to send reminder letters.
- **Breast cancer screening:** EHR identifies **female patients 40-69 years of age** who have had an office visit during the last 2 years and received a breast cancer screening during this time.
- Alert staff to complete a **hematocrit annually** for all patients **age 9 months to 23 months**.
- Alert clinical staff any **patient 12 months to 24 months** who have not received a CBC/Lead test.

Before and Now

Remember how healthcare data was exchanged prior to Electronic Health Records (EHRs)?

- Vast amount of patient data collected by clinicians
- Medical information such as vital signs, orders, prescriptions, lab notes and discharge summaries were dictated or recorded by hand
Before and Now

- All of this clinical data was stored as paper records (documents) at each point of care

Care Coordination Framework
Meaningful Use Exchange Requirements

- Provider-to-provider for transitions of care
- Provider-to-patient (to allow patients to view online, download or transmit their own health information)
- E-Prescribing
- Public Health Reporting

Summary of Care

Purpose: Ensure eligible professionals who transition a patient to another provider’s care sends the most up-to-date information available so that the next provider is able to make more informed decisions.

- When a provider transitions or refers a patient to another setting or provider of care, the EP should send a summary of care record.
- Information is generally limited to what is available in CEHRT at the time the summary of care document is generated.
Information Requirements

- Patient name
- Referring or transition provider’s name and office contact information
- Procedure
- Encounter diagnosis
- Immunizations
- Laboratory test results
- Vital signs
- Smoking Status
- Functional Status, including activities of daily living, cognitive and disability status
- Demographics
- Care plan field, including goals and instructions
- Care team including the primary care provider and any additional known care team members
- Reason for referral
- Current problem list
- Current medication list
- Current medication allergy list

Better Information Means Better Health Care

EHR adoption can give health care providers:

- **Accurate and complete information about a patient’s health.** This enables providers to give the best possible care, whether during a routine office visit or in a medical emergency, by providing the information they need to evaluate a patient’s current condition in the context of the patient’s health history and other treatments.

- **The ability to quickly provide care.** In a crisis, EHRs provide instant access to information about a patient’s medical history, allergies, and medications. This can enable providers to make decisions sooner, instead of waiting for information from test results.
Flow chart Summary of Care Document

Information Requirements for Summary of Care

Enter information into CEHRT

Withhold any information the provider determines could cause possible harm. Verify problem list, medication list, and medication allergy list

Create CCDA document to share

Associated Clinical Quality Measure –

• CMS 50
• Measure Steward - CMS
• Closing the loop: Receipt of Specialist Report

Numerator: Number of patients with a referral, for which the referring provider received a report from the provider to whom the patient was referred.

Denominator: Number of patients, regardless of age, who were referred by one provider to another provider, and who had a visit during the measurement period.
MCO Role in TOC summary exchange

- MCOs or Health Plans continually monitor members to assess hospital re-admissions within a specified time parameter, to assure health care is integrated with BH and to meet member & provider needs.

- MCO ABC has identified providers with some issues
  - Provider 1 has had several re-admissions for members hospitalized
  - Provider 2 has members with both Behavioral Health & Physical Health needs
  - Provider 3 is trying to meet NCQA standards for a recognized Patient Centered Medical Home

Example Provider 1

- A child was taken to the local ER due to an asthma attack and required hospitalization to stabilize. How can PCP1 be proactive?

- The hospital EHR can create an electronic Discharge Summary (CCDA format) and send via DIRECT messaging to PCP1. The same Discharge Summary can be printed for the parents of the child to take home – or can be added to the EHR patient portal for the child’s parents to review as needed.

- PCP1 can follow up with parents after receiving the Discharge Summary of Care document from the hospital to check on the child. If there are problems, the PCP can schedule a visit and make an assessment of the needs and prevent another hospitalization.
Example Provider 2

- Patient B has diabetes which is complicated by his bipolar disorder. How can care be coordinated?
- PCP2 can treat BH as a referral. A CCDA formatted summary of care document can be sent electronically to the BH provider showing diabetes A1c and blood glucose values.
- BH provider has important information about control or lack of control of blood glucose values in the patient to know if they are a contributing factor in recent BH issues. Treatment can be rendered, and another CCDA formatted summary of care document can be sent to the PCP documenting the BH visit, medication changes, etc. for the PCP EHR.
- Ultimately, the patient receives the care needed to control both the diabetes and the bipolar disorder. Prescriptions can be monitored by both providers of care.

Example Provider 3

- PCP3 refers a patient to an Orthopedic Surgeon to be evaluated for knee replacement. To meet NCQA standards PCP3 needs to track referrals.
- Before the referral appointment, the PCP3 sends a CCDA formatted Summary of Care document electronically to the surgeon. Therefore, the surgeon has the most recent medical history for the patient when the visit occurs.
- The surgeon recommends knee replacement. Another CCDA Summary of Care document is sent from the surgeon to PCP3 letting them know of the upcoming surgery.
- The hospital, who also uses a certified EHR, creates a CCDA formatted Discharge Summary and sends, electronically, a copy to both the PCP and the Surgeon for the EHR records.
- All of these records can be available to the patient via patient portals for each provider of care.
- Each provider of care is aware of the patient’s needs and can track progress and provide follow up care needed.
- The patient received the best care available.
- PCP3 becomes recognized by NCQA as PCMH.
- CMS 50 can be used to monitor progress.
MU Unit Staff

- Director, Cindy Wallace
  - Oversight of the MU Program.
- MU Coordinator, Krystal Massey
  - Evaluation Team Lead and data specialist.
- MU Clinical Educator, Vickie Duncan
  - Lead in provider communications and education.
- ASA4, Curtis Popp
  - Lead in SQL queries and webinar set up.
- ASA2, Cindy Rich
  - Lead in attestation & provider technical assistance scheduling and tracking.

TennCare Meaningful Use Clinical Educator

What Educator's Role Is:

- Conduct:
  - Technical Assistance call with providers as needed for assistance with attestation process.
  - Training sessions with in house staff, provider services, and other TennCare staff as needed.
  - Training sessions with MCO, and MCO representatives.
  - Training sessions with EP and their representatives as needed.
- Answer questions from TennCare mailbox with phone calls as needed.
- Follow up on any CDS rule that needs clarification with email/and or phone call as needed.
**TennCare Meaningful Use Clinical Educator**

**What Educator’s Role Is:**
- Develop:
  - Communication tools to alert providers of this new program, examples: newsletter, webpage, seminar participation.
  - Monthly webinars on subjects of interest for all Tennessee providers.
  - State wide travel schedule to be in all three regions during the calendar year for technical attestation assistance.
- Follow up on any CDS rule that needs clarification with email and/or phone call as needed.
- Conduct Onsite technical assistance visits with EP and Groups to assist with attestation process.

**TennCare Meaningful Use Clinical Educator**

**What the Educator’s Role Is Not:**
- Electronic Record technical support
- Negotiator of vendor issues
- Evaluator of attestation on site
- Submitter of EP Attestations
- Decision maker for measure selection (CQM)
- Enforcer of work flow for EHR
MU Resources

TennCare web site at http://www.tn.gov/tenncare/section/meaningful-use-overview
For more information about HealthIT.gov, http://www.healthit.gov/providers-professionals
For more information on certified EHR technology (CEHRT), visit the CMS website, http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Certification.html

Questions

EHRMeaningfulUse.TennCare@tn.gov
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