eHealth
CENTERS FOR MEDICARE & MEDICAID SERVICES

Stage 2 Exchange Requirements for Eligible Professionals

Kathleen Connors de Laguna MSPH, BSN
Health Insurance Specialist
Office of E-Health Standards and Services
November 5, 2013

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

DEPARTMENT OF HEALTH & HUMAN SERVICES · USA

www.cms.gov/eHealth

What Is Meaningful Use?

Meaningful use is using certified EHR technology to:

Improve quality, safety, efficiency, and reduce health disparities

Improve care coordination

Improve population and public health

Engage patients and families in their health care

All the while maintaining privacy and security

Meaningful use mandated in law to receive incentives

What is Interoperability?

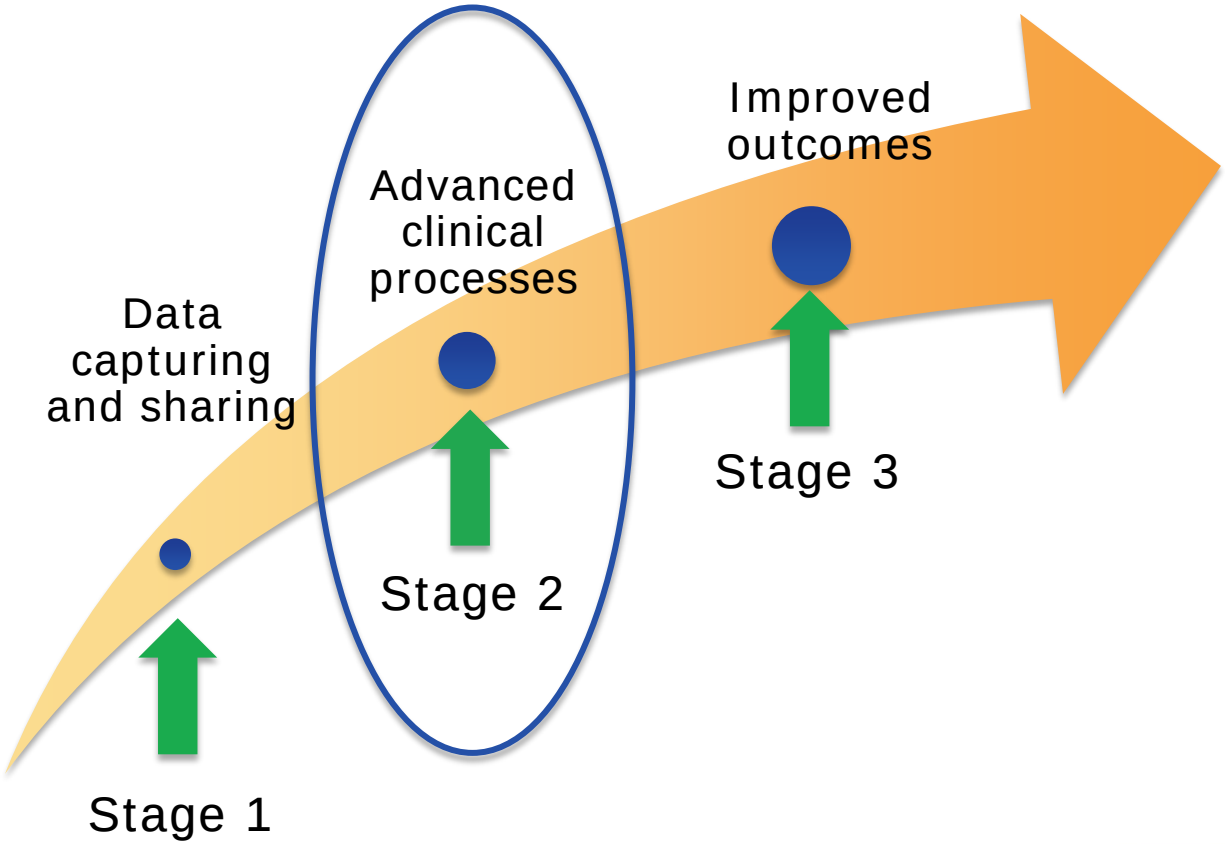
Interoperability describes extent systems and devices can exchange data and interpret shared data

For two systems to be interoperable, they must be able to exchange data and present that data such that it can be understood by a user

Why Interoperability?

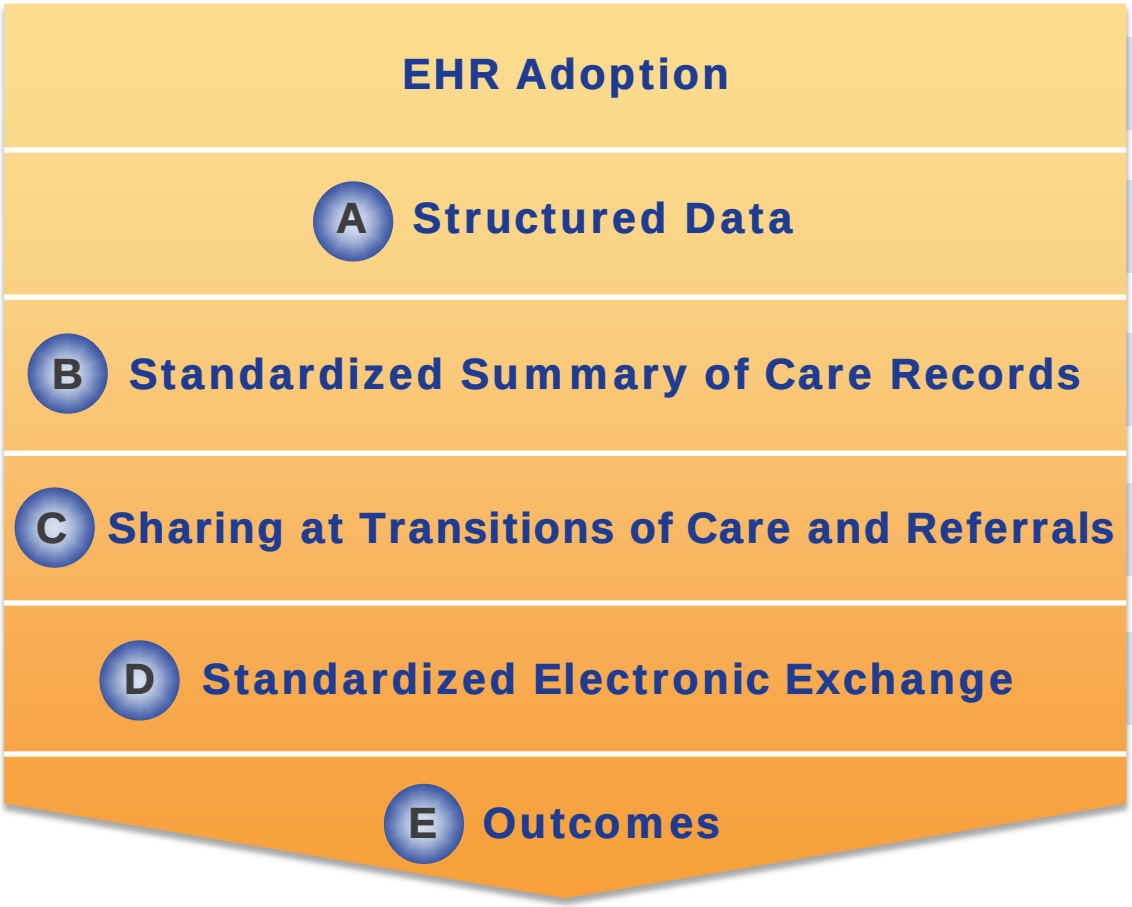
- Reduces duplication of effort
- Empower patients to access, maintain, and exchange their health information
  - View
  - Download
  - Transmit
- Streamlines communication through transitions of care

Stages of Meaningful Use



eHealth
CENTERS FOR MEDICARE & MEDICAID SERVICES

Interoperability Through Meaningful Use



eHealth
CENTERS FOR MEDICARE & MEDICAID SERVICES

A Structured Data

STAGE 1

CORE
- Problems — SNOMED CT
- Meds — Rx Norm
- Med Allergies
- Demographic Data
- Vital Signs
- Smoking Status — SNOMED CT

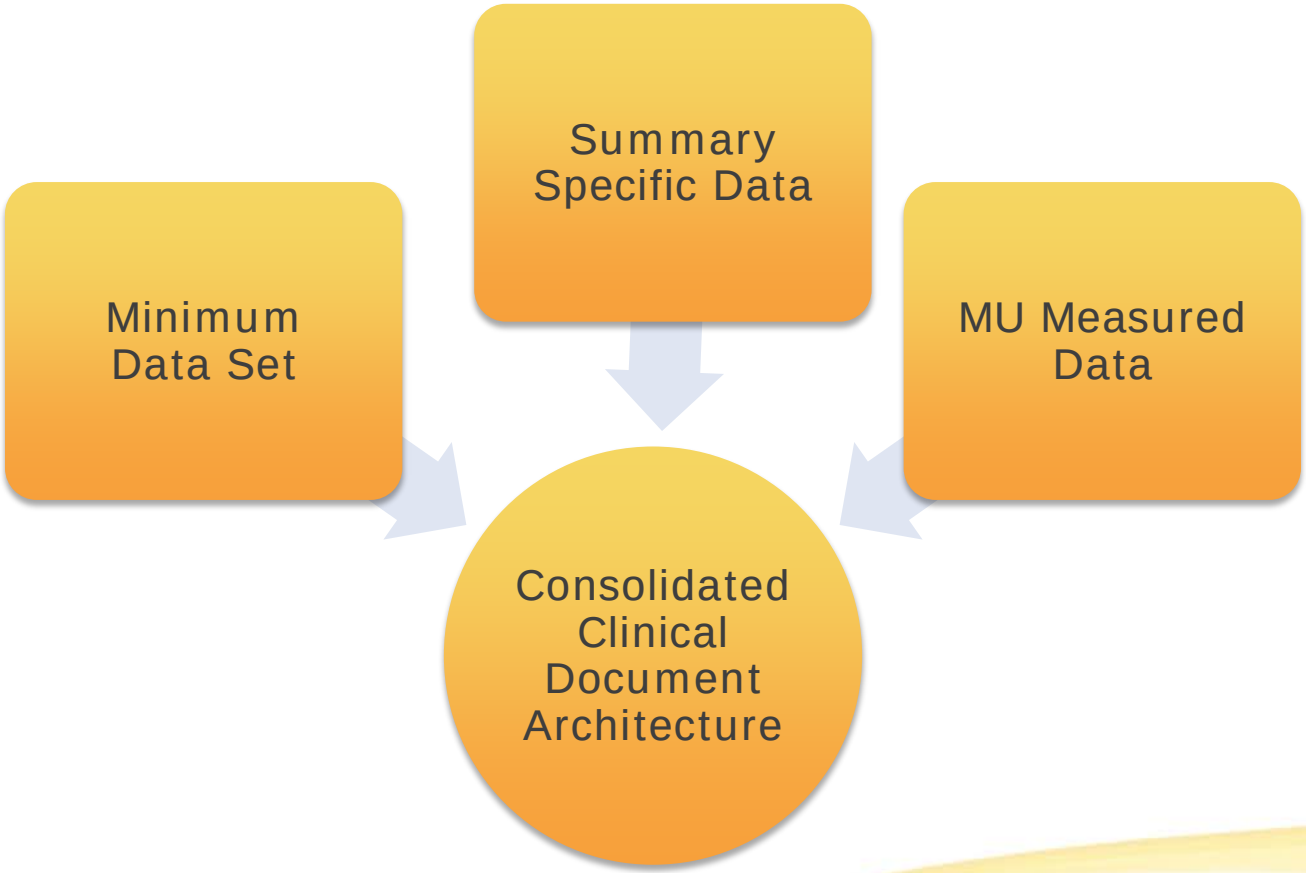
MENU
- Labs — LOINC
- Public Health — HL7

STAGE 2

CORE
- Stage 1 Core
- Labs — LOINC
- Public Health — HL7

MENU
- Family Health History
- Progress Notes

B Standardized Summary of Care Records



C Sharing at Transitions of Care and Referrals

STAGE 1

CORE

- 2013 Provide as an e-copy upon request
- 2014+ Make available online to patients

MENU

- Provide at 50% of transitions of care and referrals

STAGE 2

CORE

- Make available online to patients
- Provide at 50% of transitions of care and referrals

D Standardized Electronic Exchange

STAGE 1	**CORE** • Prep for Stage 2
STAGE 2	**CORE** • Send using one of the established standards for 10% of transitions of care and referrals • Ensure ability to conduct an electronic exchange outside your organization and across developer lines

E Outcomes

STAGE 3

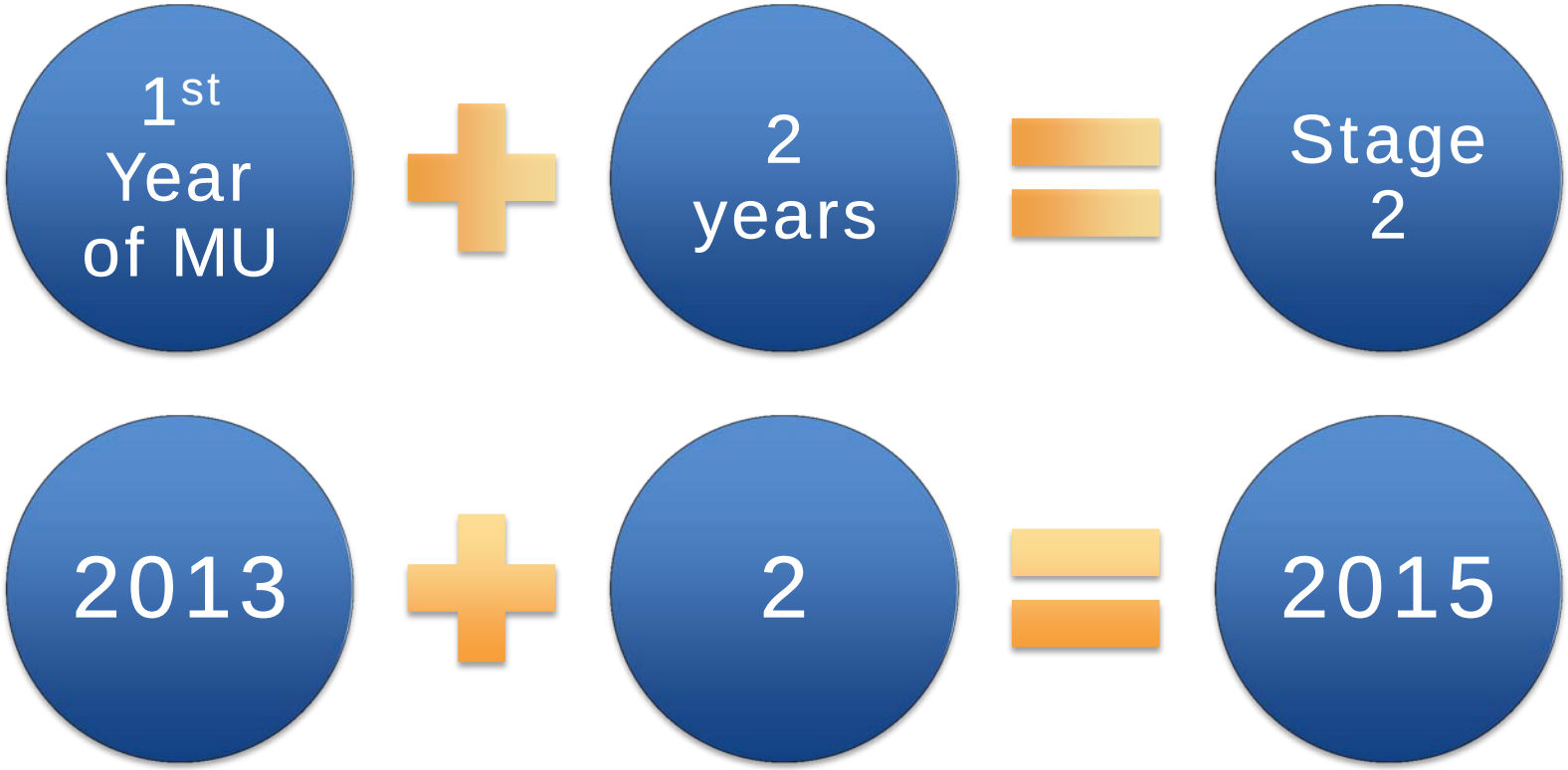
eHealth
CENTERS FOR MEDICARE & MEDICAID SERVICES

2014 Stage 1 Changes

eHealth
CENTERS FOR MEDICARE & MEDICAID SERVICES

Everyone Starts in Stage 1
No One Starts Stage 2 Before 2014

When Do I Start Stage 2?



2014 Stage 1 Changes

Some Stage 1 changes take effect in 2014:

Changes to vital signs measure become required

Reporting of clinical quality measures removed as objective but still required

Patient electronic access and electronic copy of health info objectives merge to become view online, download, and transmit (VDT) objective

2014 Change to Stage 1: E-Copy & Online Access

Change in objective takes effect in 2014 to coincide with the 2014 certification and standards criteria

Current Stage 1 Objectives

Provide patients with e-copy of health information upon request

+

Provide electronic access to health information

2014 Stage 1 Objective

Provide 50% of patients the ability to view online, download and transmit their health information

eHealth
CENTERS FOR MEDICARE & MEDICAID SERVICES

Stage 2 Exchange Requirements

Stage 2 Exchange Requirements

Meaningful use Stage 2 objectives involve a lot of health information exchange

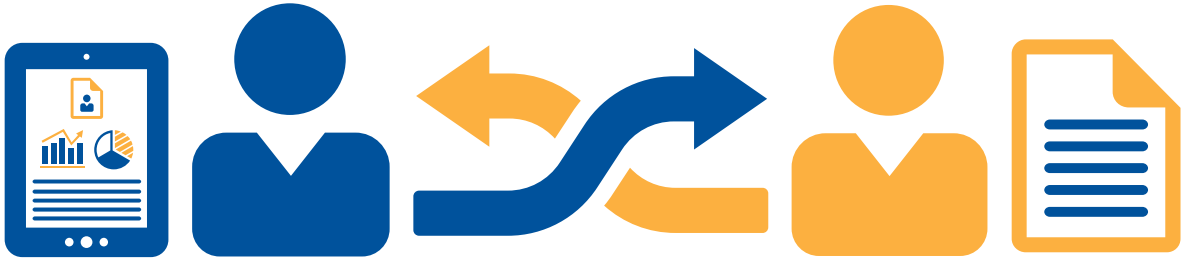
These objectives require EHR interoperability to exchange health information

Examples

- Provider-to-Provider (e.g., Transitions of Care [ToC])
- Provider-to-Patient (e.g., View, Download, Transmit [VDT])
- E-prescribing
- Lab results reporting
- Public health reporting

Types of HIE

Electronically exchanging health information requires the standardization of data.



There are currently three key forms of HIE:

1. **Directed Exchange**– ability to send and receive secure information electronically between care providers to support coordinated care

2. **Query-based Exchange**– ability for providers to find and/or request information on a patient from other providers, often used for unplanned care

3. **Consumer Mediated Exchange**– ability for patients to aggregate and control the use of their health information among providers

Stage 2 Objectives

Three Stage 2 objectives requiring exchange:

1. Summary of Care

2. Clinical Summary

3. Patient Electronic Access

- Some of the data elements are common between these three objectives
- Other data elements are individual to each objective

eHealth
CENTERS FOR MEDICARE & MEDICAID SERVICES

1. Summary of Care

Summary of Care

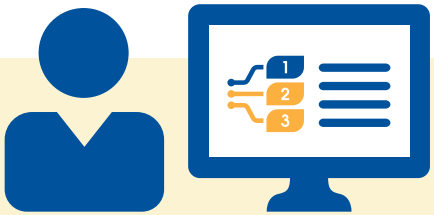
Objective	EP who transitions patient to another setting of care or provider of care or refers patient to another provider of care should provide summary care record for each transition of care or referral
Measures	EPs must satisfy both of the following measures in order to meet the objective: **Measure 1:** EP who transitions or refers 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 **Measure 2:** EP who transitions or refers patient to another setting of care or provider of care provides a summary of care record for more than 10% of such transitions and referrals either (a)electronically transmitted using CEHRT to a recipient or (b) where the recipient receives the summary of care record via exchange facilitated by an organization that is a NwHIN Exchange participant or in a manner that is consistent with the governance mechanism ONC establishes for the NwHIN **Measure 3:** EP must satisfy one of following criteria: • Conducts one or more successful electronic exchanges of a summary of care document, as part of which is counted in "measure 2" (for EPs the measure at §495.6(j)(14)(ii)(B) with a recipient who has EHR technology that was developed designed by a different EHR technology developer than the sender's EHR technology certified to 45 CFR 170.314(b)(2) • Conducts one or more successful tests with the CMS designated test EHR during the EHR reporting period
Exclusion	EP who transfers a patient to another setting or refers a patient to another provider less than 100 times during EHR reporting period is excluded

Why Summary of Care?

Purpose: Ensure provider who transitions a patient to someone else's care gives receiving provider most up-to-date information available

- When EP transitions patient to another setting or provider of care, or refers patient to another provider, EP should provide a summary of care record for next provider of care
- Information generally limited to what is available to EP and in certified EHR technology at time summary of care is generated.

Measure Guidance



- Unlike clinical summary and patient online access objectives, EP **must** verify that info was entered into EHR for problem list, medication list, medication allergy list, and care plan prior to generating summary of care
- Problem list, medication list, medication allergy list, and care plan must either contain specific information or a notation that the patient has none of these items
- Leaving field blank would not allow provider to meet objective
  - If other data elements from required list is not available in EHR at time summary of care is generated, that info does not have to be made available in summary of care
- Fields for problem list, medication list, medication allergy list, and care plan must either contain problems, medications, and medication allergies, and a care plan, or a specific notation that patient has none of these items

Information Requirements for Summary of Care

Information Requirements for Summary of Care Measure

- Patient name
- Referring or transitioning provider's name and office contact information (EP only)
- Procedure
- Encounter diagnosis
- Immunizations
- Laboratory test results
- Vital signs (height, weight, blood pressure, BMI)
- Smoking Status
- Functional Status, including activities of daily living, cognitive and disability status
- Demographic information (preferred language, sex, race, ethnicity, date of birth)
- Care plan field, including goals and instructions**
- Care team including the primary care provider of record and any additional known care team members beyond the referring or transitioning provider and the receiving provider
- Reason for referral
- Current problem list (EPs may also include historical problems at their discretion)**
- Current medication list**
- Current medication allergy list**

**Required Fields

Enter information into certified EHR technology

Withhold any information provider determines could cause possible harm

Verify presence of elements; Problem List, Medication List, and Medication Allergy List

Create C-CDA

Provide summary of care record when patient is transferred to another setting of care or referred to another provider

eHealth
CENTERS FOR MEDICARE & MEDICAID SERVICES

2. Clinical Summary

Clinical Summary

Objective	Provide clinical summaries for patients for each office visit
Measure	Clinical summaries provided to patients or patient-authorized representatives within one business day for more than 50% of office visits
Exclusion	EP who has no office visits during the EHR reporting period is excluded

Why Clinical Summary?

Purpose: Provides Patients and their families with a record of:

- Office visit
- Specific lab tests
- Follow-up actions
- Treatment related to the visit

- While this information is part of patient's overall EHR, clinical summary highlights information relevant to patient's care at that particular moment
- Because it is designed to be linked to a particular office visit and provided to patient either at conclusion of visit or shortly thereafter, information required for clinical summary is limited to information available in EHR at time clinical summary is provided

Measure Guidance

- If an EP has not yet entered specific data element into EHR at time the clinical summary is provided, that field can be left blank and EP can still meet objective
- If listed info is available in EHR at time clinical summary is provided, it must also be included in clinical summary (except as described below).
- All info listed in measure and available in certified EHR at time clinical summary is provided must be part of clinical summary provided to patient
- Clinical summary can be provided either online or on paper. However, EP may withhold any info from clinical summary if he or she believes that providing such info may result in significant harm

Information Requirements for Clinical Summary

Information Requirements for Clinical Summary Measure

- Patient name
- Provider's name and office contact information
- Date and location of the visit
- Reason for the office visit
- Current problem list
- Current medication list
- Current medication allergy list
- Procedures performed during the visit
- Immunizations or medications administered during the visit
- Vital signs taken during the visit (or other recent vital signs)
- Laboratory test results
- List of diagnostic tests pending
- Clinical instructions
- Future appointments
- Referrals to other providers
- Future scheduled tests
- Demographic information maintained within certified electronic health record technology (CEHRT) (sex, race, ethnicity, date of birth, preferred language)
- Smoking status
- Care plan field(s), including goals and instructions
- Recommended patient decision aids (if applicable to the visit)

Enter information into certified EHR technology at the time of the office visit

Withhold any information provider determines could cause possible harm

Provide modified information in clinical summary to patient (either online or on paper) within one (1) business day

eHealth
CENTERS FOR MEDICARE & MEDICAID SERVICES

3. Patient Electronic Access

Patient Electronic Access

Objective	Provide patients ability to view online, download and transmit their health info within 4 business days of the info being available to EP
Measure	**Measure 1:** More than 50% of all unique patients seen by EP during EHR reporting period provided timely (available to patient within 4 business days after info available to EP) online access to their health info **Measure 2:** More than 5% of all unique patients seen by EP during EHR reporting period (or their authorized representatives) view, download, or transmit to a third party their health info
Exclusion	EP who: **(1)** Neither orders nor creates any info listed for inclusion as part of both measures, except for "Patient name" and "Provider's name and office contact info, may exclude both measures **(2)** Conducts 50% or more of patient encounters in a county that does not have 50% or more of its housing units with 3Mbps broadband availability according to latest info available from FCC on first day of EHR reporting period may exclude only second measure

Why Patient Electronic Access?

Purpose: Allows patients easy access to health info so they can make informed decisions regarding care and share most recent clinical info with other health care providers and personal givers

- Requirements for patient electronic access are similar to those for clinical summaries
- Patient electronic access measure requires EPs to provide patients ability to view online, download, and transmit their health information within four (4) business days of information being available to provider

Measure Guidance

- Unlike clinical summaries, which are tied to specific office visits, providing patient electronic access to info is ongoing requirement
- If a specific data field is not available to EP at time info is sent to patient portal, that info does not have to be made available online and EP can still meet objective
- As new info for specific items listed becomes available to provider, that info must be updated and made available to patient online within four (4) business days

- All info available at time info is sent to patient portal must be made available to patient online
- EP may withhold any info from online disclosure if he or she believes providing such info may result in significant harm
- Fields for problem list, medication list, medication allergy list, and care plan must either contain problems, medications, and medication allergies, or a specific notation that patient has none

Information Requirements for Patient Access

Information Requirements for Clinical Summary Measure

- Patient name
- Provider's name and office contact information
- Current and past problem list
- Procedures
- Laboratory test results
- Current medication list and medication history
- Current medication allergy list and medication allergy history
- Vital signs (height, weight, blood pressure, BMI growth charts)
- Smoking status
- Demographic Information (preferred language, sex, race, ethnicity, date of birth)
- Care plan field(s), including goals and instructions
- Any known care team members including the primary care provider (PCP) of record

Unless the information is not available in certified HER technology (CEHRT), is restricted from disclosure due to any federal, state, or local law regarding the privacy of a person's health information, including variations due to the age of the patient, or the provider believes that substantial harm may arise from disclosing particular health information in this manner.

Enter information into certified EHR technology as it becomes available

Withhold from online disclosure any information provider determines could cause possible harm

Make modified information available to patient online within four (4) business days

eHealth
CENTERS FOR MEDICARE & MEDICAID SERVICES

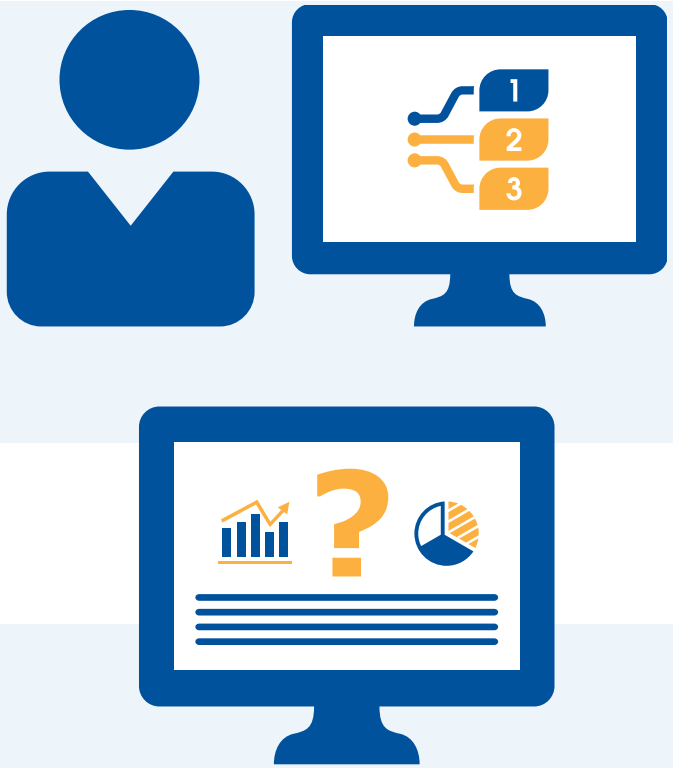
Talking Exchange With Your EHR Vendor

Exchange Options

- When will the vendor product be ready for installation and use?
- What services does the vendor offer?
- Does the vendor have HIE capabilities within their EHR?
- What form(s) of exchange does their EHR support?
- If/how will they be able to work with other organizations to facilitate exchange (e.g., state/regional HIEs, national HISPs, etc.)?
- How does their software/service help to ensure that you will have ability to exchange with a sufficient number of other providers?

Steps to Ensure Exchange

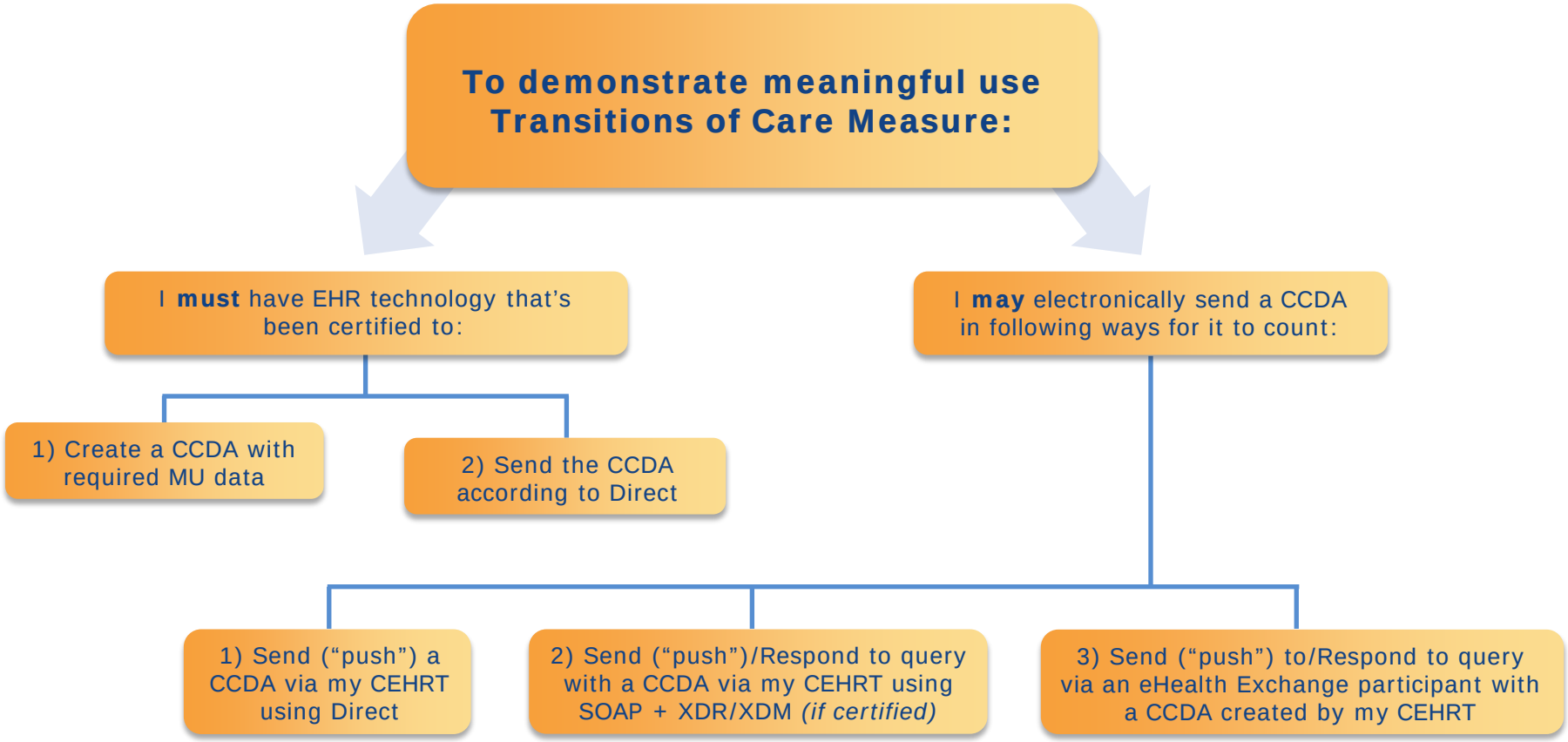
- Ask vendors to explain steps they (or their partners) have taken to facilitate cross-vendor, cross-enterprise exchange:
  - Footprint/reach of their HIE services
  - Optional transport standards that enable use of other HISP/HIE organizations
  - Participation in a trust community, such as DirectTrust
- Do they work with Regional Extension Centers to make sure these elements of their implementation are clear?
- As their software counts numerators and denominators for measures, what will output / reports look like?
- What detailed data does their software/service offer in case of an audit?



Exchange Services Costs

- Ask vendor to provide:
  - One-time costs
  - Recurring costs
  - fees associated with interfacing to 3rd-parties
- Vendors are required by regulation to disclose any costs providers will incur to use certified tools/services other than “sticker price” upfront

Creating and Sending CCDA



Resources

- CMS Program Website www.cms.gov/EHRincentiveprograms
- ONC Program Website www.healthit.gov
- Is my EHR certified? http://oncchpl.force.com/ehrcert?q=CHPL

Questions?

Contact Information

Kathleen Connors de Laguna
Office of E-Health Standards and Services
Kathleen.Connorsdelaguna@cms.hhs.gov

Vidya Sellappan
Office of E-Health Standards and Services
Vidya.Sellappan@cms.hhs.gov