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On the topic:

Meaningful Use Reporting Deadline
March 13th

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MM, CMC, CMIS, CMOM
PMI Faculty
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Meaningful Use Reporting
Deadline Extended

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Overview

• About the EHR Incentive Program
• Deadlines and Payment Adjustments
• MACRA
• Challenges with transitioning to EHR
• Possible solutions for Success
• Benefits of EHR/meaningful Use
About the EHR Incentive Program


• Title IV of Division B of ARRA amends Titles XVIII and XIX of the Social Security Act (the Act) by establishing incentive payments to eligible professionals (EPs), eligible hospitals, and critical access hospitals (CAHs), and Medicare Advantage Organizations to promote the adoption and meaningful use of interoperable health information technology (HIT) and qualified electronic health records (EHRs).

• These incentive payments are part of a broader effort under the HITECH Act to accelerate the adoption of HIT and utilization of qualified EHRs.

Source: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/Payment-Adjustment-Information.html

• Beginning in 2011, the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs were established to encourage eligible professionals and eligible hospitals to adopt, implement, upgrade (AIU), and demonstrate meaningful use of certified EHR technology.
• **Stage 1** set the foundation for the EHR Incentive Programs by establishing requirements for the electronic capture of clinical data, including providing patients with electronic copies of health information.

• **Stage 2** expanded upon the Stage 1 criteria with a focus on ensuring that the meaningful use of EHRs supported the aims and priorities of the National Quality Strategy. Stage 2 criteria encouraged the use of health IT for continuous quality improvement at the point of care and the exchange of information in the most structured format possible.

• In October 2015, CMS released a [final rule](https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/EHRIncentivePrograms/Final-Rules-for-Stage-2-Meaningful-Use-Criteria-2015/index.html) that specifies criteria that eligible professionals, eligible hospitals and CAHs must meet in order to participate in the EHR Incentive Programs in 2015 through 2017 (Modified Stage 2) and in Stage 3 in 2017 and beyond.

• Under the new requirements, there is no longer a designation between core and menu measures.

• All eligible professionals must report on the Modified Stage 2 (10) mandatory objectives for 2015 through 2017. There were exclusions and specifications for providers in 2015 and 2016 depending which Stage of Meaningful Use the provider was scheduled to report.

• By 2018, all providers will be required to move to Stage 3 Meaningful Use. The Meaningful Use program will become one component of the Merit Based Incentive Program in 2019 based on 2017 reporting.

• Please see the next slides for details on the reporting periods, the required objectives and measures and hardship exemptions.
### Stage of Meaningful Use Criteria by First Reporting Year

<table>
<thead>
<tr>
<th>First Year Demonstrating Meaningful Use</th>
<th>2015</th>
<th>2016</th>
<th>2017</th>
<th>2018</th>
<th>2019</th>
</tr>
</thead>
<tbody>
<tr>
<td>2011 Modified Stage 2</td>
<td>Modified</td>
<td>Modified</td>
<td>Modified</td>
<td>Stage 3</td>
<td>Stage 3</td>
</tr>
<tr>
<td>2012 Modified Stage 2</td>
<td>Modified</td>
<td>Modified</td>
<td>Modified</td>
<td>Stage 3</td>
<td>Stage 3</td>
</tr>
<tr>
<td>2013 Modified Stage 2</td>
<td>Modified</td>
<td>Modified</td>
<td>Modified</td>
<td>Stage 3</td>
<td>Stage 3</td>
</tr>
<tr>
<td>2014 Modified Stage 2</td>
<td>Modified</td>
<td>Modified</td>
<td>Modified</td>
<td>Stage 3</td>
<td>Stage 3</td>
</tr>
<tr>
<td>2015 Modified Stage 2</td>
<td>Modified</td>
<td>Modified</td>
<td>Modified</td>
<td>Stage 3</td>
<td>Stage 3</td>
</tr>
<tr>
<td>2016 Modified Stage 2</td>
<td>Modified</td>
<td>Modified</td>
<td>Modified</td>
<td>Stage 3</td>
<td>Stage 3</td>
</tr>
</tbody>
</table>

### Objectives and Measures for Providers

**Objectives for 2015, 2016 and 2017**

- **Protect Patient Health Information**
  - Measure: Conduct or review a security risk analysis (including addressing security of electronic public health information created or maintained by CHERT), implement security updates as necessary and correct identified security deficiencies as part of the eligible professionals risk management process.
  - Alternative Exclusions and/or Specifications for Certain Providers: None

- **Clinical Decision Support**
  - Measure 1: Implement five clinical decision support interventions related to four or more clinical quality measures at a relevant point in patient care for the entire EHR reporting period. Absent four or more clinical quality measures related to an EP’s scope of practice or patient population, the clinical decision support interventions must be related to high-priority health conditions.
  - Measure 2: The eligible professional has enabled and implemented the functionality for drug and drug-allergy interaction checks for the entire EHR reporting period.

- Alternative Objective and Measure 1: If for an EHR reporting period in 2015 the provider is scheduled to demonstrate stage 3:
  - Objective: Implement one clinical decision support rule relevant to your specialty or a high clinical priority, along with the ability to track compliance within that rule.
  - Measure: Implement one clinical decision support rule.
### Objectives and Measures for Providers

<table>
<thead>
<tr>
<th>Computerized Provider Order Entry (CPOE)</th>
<th>Alternate Measure 1:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Measure 1:</strong> More than 60 percent of medication orders created by the EP during the EHR reporting period are recorded using CPOE.</td>
<td><strong>For Stage 1 providers in 2015 only,</strong> more than 30 percent of all unique patients with at least one medication in their medication list seen by the EP during the EHR reporting period have at least one medication order entered using CPOE; or more than 30 percent of medication orders created by the EP during the EHR reporting period, are recorded using CPOE.</td>
</tr>
<tr>
<td><strong>Measure 2:</strong> More than 30 percent of laboratory orders created by the EP during the EHR reporting period are recorded using CPOE.</td>
<td><strong>Alternate Exclusion for Measure 1:</strong> Providers scheduled to be in Stage 1 in 2015 may claim an exclusion for measure 2 (laboratory orders) of the Stage 2 CPOE objective for an EHR reporting period in 2015; and, providers scheduled to be in Stage 1 in 2016 may claim an exclusion for measure 2 (laboratory orders) of the Stage 2 CPOE objective for an EHR reporting period in 2016.</td>
</tr>
<tr>
<td><strong>Measure 3:</strong> More than 30 percent of radiology orders created by the EP during the EHR reporting period are recorded using CPOE.</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Electronic Prescribing</th>
<th>Alternate EP Measure: For Stage 1 providers in 2015 only, More than 40 percent of all permissible prescriptions written by the EP are transmitted electronically using CEHRT.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Measure:</strong> More than 50 percent of all permissible prescriptions written by the EP are queried for a drug formulary and transmitted electronically using CEHRT.</td>
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</tbody>
</table>

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<thead>
<tr>
<th>Health Information Exchange</th>
<th>Alternate Exclusion: Provider may claim an exclusion for the measure of the Stage 2 Summary of Care objective, which requires the electronic transmission of a summary of care document if for an EHR reporting period in 2015, they were scheduled to demonstrate Stage 1, which does not have an equivalent measure.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Measure:</strong> The EP that transitions or refers their patient to another setting of care or provider of care (1) uses CEHRT to create a summary of care record; and (2) electronically transmits such summary to a receiving provider for more than 10 percent of transitions of care and referrals.</td>
<td></td>
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## Objectives and Measures for Providers

<table>
<thead>
<tr>
<th>Objective</th>
<th>Measure</th>
<th>Alternate Exclusion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient-Specific Information</td>
<td>Patient-specific education resources identified by CEHR are provided to patients for more than 10 percent of all unique patients with office visits seen by the EP during the EHR reporting period.</td>
<td>Provider may claim an exclusion for the measure of the Stage 2 Patient-Specific Education objective if for an EHR reporting period in 2015, they were scheduled to demonstrate Stage 1 but did not intend to select the Stage 1 Patient-Specific Education menu objective.</td>
</tr>
<tr>
<td>Medication Reconciliation</td>
<td>The EP performs medication reconciliation for more than 50 percent of transitions of care in which the patient is transitioned into the care of the EP</td>
<td>Provider may claim an exclusion for the measure of the Stage 2 Medication Reconciliation objective if for an EHR reporting period in 2015, they were scheduled to demonstrate Stage 1 but did not intend to select the Stage 1 Medication Reconciliation menu objective.</td>
</tr>
<tr>
<td>Patient Electronic Access</td>
<td>More than 50 percent of all unique patients seen by the EP during the EHR reporting period are provided timely access to view online, download, and transmit to a third party their health information subject to the EP’s discretion to withhold certain information.</td>
<td>Providers may claim an exclusion for the second measure if for an EHR reporting period in 2015, they were scheduled to demonstrate Stage 1, which does not have an equivalent measure.</td>
</tr>
</tbody>
</table>

## Objectives and Measures for Providers

| Measure 2: For 2015 and 2016 | At least 1 patient seen by the EP during the EHR reporting period (or patient-authorized representative) views, downloads or transmits his or her health information to a third party during the EHR reporting period. |
### Objectives and Measures for Providers

#### Secure Messaging

**Measure:**
- For 2015: For an EHR reporting period in 2015, the capability for patients to send and receive a secure electronic message with the EP was fully enabled.
- For 2016: For at least 1 patient seen by the EP during the EHR reporting period, a secure message was sent using the electronic messaging function of CEMHR to the patient (or patient authorized representative), or in response to a secure message sent by the patient (or patient authorized representative) during the EHR reporting period.
- For 2017: For more than 5 percent of unique patients seen by the EP during the EHR reporting period, a secure message was sent using the electronic messaging function of CEMHR to the patient (or patient authorized representative), or in response to a secure message sent by the patient (or patient authorized representative) during the EHR reporting period.

**Alternate Exclusion:** An eligible professional may claim an exclusion for the measure if for an EHR reporting period in 2015, they were scheduled to demonstrate Stage 1, which does not have an equivalent measure.

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### Objectives and Measures for Providers

#### Public Health

**Measure 1: Immunization Registry Reporting:**
The EP is in active engagement with a public health agency to submit immunization data.

**Measure 2: Syndromic Surveillance Reporting:**
The EP is in active engagement with a public health agency to submit syndromic surveillance data. **Measure 3: Specialized Registry Reporting** – The EP is in active engagement to submit data to a specialized registry.

**Stage 1:** EPs in 2015 must meet at least 1 measure in 2015.
**Stage 2:** EPs must meet at least 2 measures in 2015, and all EPs must meet at least 2 measures in 2016 and 2017.

**NOTE:** Ophthalmologists can claim exclusions for the first two public health measures. Since there is an ophthalmic clinical data registry that providers could have engaged with in 2015 up until the last quarter, our members will not be able to claim an exclusion for this objective if they choose to report a 90-day period prior to September. Currently, the IRIS data registry is closed for the remainder of 2015, and therefore, if providers choose to report for the last 90 days then they can claim an exclusion for this measure. We are working with CMS to resolve this issue.

**Alternate Exclusion Measure 1:**
Any EP, eligible hospital, or CAH meeting one or more of the following criteria may be excluded.
Payment Adjustments

• In the American Recovery and Reinvestment Act of 2009 (ARRA), Congress mandated that payment adjustments should be applied to Medicare eligible professionals, eligible hospitals, and critical access hospitals (CAH) that are not meaningful users of Certified Electronic Health Record (EHR) Technology under the Medicare EHR Incentive Program.

• If a provider is eligible to participate in the Medicare EHR Incentive Program, they must demonstrate meaningful use in either the Medicare EHR Incentive Program or in the Medicaid EHR Incentive Program, to avoid a payment adjustment. Medicaid providers who are only eligible to participate in the Medicaid EHR Incentive Program are not subject to these payment adjustments.

Hardship Exemptions for Medicare Eligible Professionals

• Eligible professionals may apply for hardship exceptions to avoid the payment adjustments described above.

• Hardship exceptions will be granted only under specific circumstances and only if CMS determines that providers have demonstrated that those circumstances pose a significant barrier to their achieving meaningful use.

• Unfortunately, the deadline to submit an EHR Incentive Program Hardship Exception application to avoid the 2017 Medicare EHR payment adjustment has passed. For inquiries about Hardship Exception Applications, please email ehrhardship@provider-resources.com.
Hardship Exceptions Categories

- **Lack of Infrastructure**: Eligible professionals must demonstrate that they are in an area without sufficient internet access or face insurmountable

- **Extreme and Uncontrollable Circumstances**: Examples may include a natural disaster or other unforeseeable barrier.
  - **EHR Vendor Issues**: The eligible professional’s EHR vendor was unable to obtain certification or the eligible professional switched vendors barriers to obtaining infrastructure (e.g., lack of broadband).

- **Patient Interaction**:
  - Lack of face-to-face or telemedicine interaction with patient
  - Lack of follow-up need with patients

- **Practice at Multiple Locations**: Lack of control over availability of CEHRT for more than 50% of patient encounters.

Deadline Extended for 2016

The Centers for Medicare & Medicaid Services (CMS) has extended the attestation deadline for providers participating in the Medicare EHR Incentive Program to:

**Monday, March 13, 2017, at 11:59 p.m. ET.**

Eligible Professional (EP) Reconsideration Form

• The deadline for Eligible Professionals to submit Reconsideration forms for the 2017 payment adjustment, based on the 2015 EHR reporting period is March 13, 2017.

• No applications will be accepted after the deadline. For inquiries about the Reconsideration Application, please email pareconsideration@provider-resources.com.

New Participants in 2016

• In 2016, the EHR reporting period for a payment adjustment year for EPs who are new participants is any continuous 90-day period in 2016.

• New participants who successfully demonstrated meaningful use for this period and satisfied all other program requirements avoided the payment adjustment in CY 2017 if the EP successfully attested by October 1, 2016, and will avoid the payment adjustment in CY 2018 if the EP successfully attests by March 13, 2017.
Returning Participants in 2016

• In 2016, the EHR reporting period for a payment adjustment year for EPs who are returning participants is the full CY 2016.

• Returning participants who successfully demonstrate meaningful use for this period and satisfy all other program requirements will avoid the payment adjustment in CY 2018 if the EP successfully attests by March 13, 2017.

EHR Incentive Program Resources

• How to Participate in the EHR Incentive Programs
  ▪ Are you ready to register and/or attest?
  ▪ Visit the Registration and Attestation page
  ▪ Review the checklists to help you prepare to participate.

Penalties

• Medicare’s Electronic Health Records (EHR) Incentive Program, popularly known as meaningful use, is being phased out for physicians this year.

• But physicians must still report on the meaningful use measures for 2016 to avoid a 3% penalty in 2018. About 171,000 physicians are expected to be penalized this year because they didn't attest to meaningful use for 2015, according to CMS.

Deadlines/Timeline

<table>
<thead>
<tr>
<th>Dates to Remember</th>
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<tbody>
<tr>
<td>2017 EHR Incentive Programs Reporting Period</td>
<td>January 1 – December 31, 2017</td>
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<tr>
<td>HIMSS17</td>
<td>February 19 – 23, 2017</td>
</tr>
<tr>
<td>2017 EP Payment Adjustment Reconsideration Application</td>
<td>February 28, 2017</td>
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<tr>
<td>Deadline</td>
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<tr>
<td>CY 2016 EHR Incentive Programs Attestation and eCOM</td>
<td>March 13, 2017</td>
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<tr>
<td>Submission Deadline</td>
<td></td>
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<tr>
<td>Deadline for Appeal Filing for eCOM</td>
<td>March 28, 2017</td>
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<tr>
<td>Reporting/Eligibility/Failed Reporting Meaningful Use</td>
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<tr>
<td>CY 2017 EHR Incentive Programs Attestiation Deadline</td>
<td>October 1, 2017</td>
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<td>for First-Time Participants</td>
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MU to become QPP

• As you have probably heard, starting in 2017 the Medicare EHR Incentive Program (Meaningful Use) will become part of the Quality Payment Program (QPP) under the MACRA law.

• The Medicaid EHR Incentive Program will remain as is, and will be a separate program.
Medicare Access and CHIP Reauthorization Act of 2015 (MACRA)

• On November 4, 2016, CMS published the Medicare Program; Merit-based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive under the Physician Fee Schedule, and Criteria for Physician-Focused Payment Models final rule with comment period (CMS-5517-FC) which establishes the MIPS, a new program for certain Medicare-enrolled practitioners.

• MIPS consolidates components of three existing programs:
  1. Physician Quality Reporting System (PQRS),
  2. Physician Value-based Payment Modifier (VM),
  3. Medicare EHR Incentive Program for Eps

• MIPS focuses on quality—both a set of evidence-based, specialty-specific standards as well as practice based improvement activities; cost; and use of CEHRT to support interoperability and advanced quality objectives in a single, cohesive program that avoids redundancies

• If you have providers that are currently meeting the requirements of the Meaningful Use program, they should meet the requirements under the Quality Payment Program. In certain cases, it may be easier.

• There are two components of the Quality Payment Program (QPP):
  ▪ MIPS (Merit-Based Incentive Payment System)
  ▪ APM (Alternative Payment Model)

• What we know of as Meaningful Use is a performance category under the MIPS component called Advancing Care Information (ACI).
Advancing Care Information Measures for 2017

• These are the measures required for 2017 ACI reporting (for required measures you only have to report 1 numerator for each threshold measure and be able to attest “yes” for the SRA measure to pass the ACI category, to get the base score):
  - security risk assessment (SRA)
  - E-Prescribing
  - provide patient access (Patient Portal)
  - health information exchange

• Additional measures you can report in 2017 for higher scoring:
  - view, download or transmit electronic patient information
  - patient-specific education
  - secure messaging
  - medication reconciliation
  - public health reporting
• Under MIPS the following provider types are eligible, so you may need to set them up in your EHR to begin collecting data for them, since they were not eligible for the Medicare MU program:
  ▪ MD
  ▪ PA
  ▪ NP
  ▪ CNS
  ▪ CRNA

• If you have providers that are eligible for the Quality Payment Program (Medicare) and also for the Medicaid EHR Incentive Program (Meaningful Use), they will need to meet and attest to the requirements for both programs.

• In 2018, part of the requirement for the ACI performance category is use of a 2015 certified version of EHR.
Quality Payment Program

• If you need additional information about the Quality Payment Program and the Advancing Care Information category for MIPS (Merit-Based Incentive Payment System, please visit http://qpp.cms.gov.

CHALLENGES WITH TRANSITIONING TO EHR
Challenges

• Researchers found that provider engagement and administrative issues were prevalent issues for all of the provider groups.

• Other issues included:
  - Selecting a vendor
  - Implementation/installation delays
  - Practice workflow disruption

Detailed Practice Analysis for Vendor Selection

• Before looking at any system in detail, it is essential that you identify the EHR requirements tailored to your practice needs. Key questions that you should ask:
  - Why are we using electronic health records?
  - Who will be managing the new system?
  - Who will require access to the system?
  - Will EHR serve our medical billing operations?
  - What patient populations are we documenting? (i.e. pediatrics, geriatrics, outpatient vs. inpatient, hospital systems, specialty niche etc.)
  - What hardware do we have in place?
  - Will this hardware be able to support a modern EHR system, or will we have to replace certain hardware components?
  - What compliance and insurance documentation requirements do we have?
  - Do I need an EHR that also works as a management/productivity/reporting system?
• In order to answer these questions, and to better understand what your practice needs, you must speak directly with the physicians and all staff members who will be utilizing the EHR system.

• One strategy for getting valuable input would be to create a brief but thorough survey to be completed by your practice staff.

• Key stakeholders include:
  - clinical staff members (who will be using the EHR system day in and day out)
  - support staff (reception, billing and operations team)
  - insurance and accounting team (need EHR access to process financials)

• Your board members, owners, and management team will have other concerns, including cost of operations and extent of training.
EHR Selection Team

• Once you have built an EHR selection team representative of your practice structure, you can begin to develop a prioritized list of EHR requirements which will allow you to eliminate systems that are less than qualified for your practice.

• The process of building a well-balanced, practical EHR selection team involves a lot of work, but if you don’t take a considered approach, you may miss out on the key needs of your team.

• A poor requirements gathering phase leads to money wasted on inadequate systems and the risk of losing excellent clinicians because of poor operations. In the end, patient care could suffer.

Analyze and Prioritize Practice Requirements

• Having formed your EHR selection team, you must begin to perform a detailed analysis of practice requirements.

• You will need a well documented and thoughtfully prioritized set of requirements in order to identify the closest match possible.
• The next step in evaluating your EHR vendor “favorite’s list” is to cross-reference each proposal with the list of prioritized requirements you developed for your EHR system. Focusing on your top three priorities, analyze how closely each proposal meets your needs.

• Keep it simple, a grading system involving something as simple as a 3- or 5-point scale works well.

• Assign low scores to sections that do not satisfy your needs and high scores to those that address your requirements accurately and extensively.

• When reviewing your EHR vendor “favorite’s list”, it is also important to meet with your team during the selection process.

• You may benefit from creating a selection committee to review the proposals. Your selection committee should include representatives of clinicians, manager, and an administrative member. This way, you will have input from all user groups and personnel within your practice.

• Of course, cost will be of great importance, so if you find a proposal that is completely out of your budget, you can easily remove it from your list.

• However, remember there is typically some room for negotiation when it comes to costs. You should also consider the fact that a quality EHR system is highly valuable to your practice, so expect to pay for this quality.
Scheduling Software Demos

• After you have identified the vendors that best match your needs, it is time to see the EHR systems in action. To do this, you will need to conduct software demonstrations with the vendor representatives.

• You will want to limit your software demonstrations to 3–5 vendors to avoid confusion and simplify your process.

• Contact each vendor from the “favorite’s list” and set up a time for demonstrations a week or two ahead of time so you can be organized and include your key stakeholders and selection committee in the process.

• Inform your vendor contact you are interested in seeing a software demonstration at your practice location. Many vendors do the demo remotely and they can be quite effective.

• Give them a list of points you would like covered in your meeting so the sales representative can prepare accordingly.

• During your product demonstration, be sure to have your key stakeholders present, including clinicians, operations management, and administration team members. Allow your clinicians to ask questions regarding the input/workflow/billing of a specific patient situation.

• Create a “real-life” problem, and ask the representative to show you how it would be documented in the system. This will allow you to better analyze ease of use and functionality within the context of your clinic.
• One of the factors that will affect your final purchase decision will be how well the clinical, operations, and administrative team members responded to the proposals and demonstrations.

• Foremost, you want your clinical staff members to feel they have their needs met. Give their opinions high merit, as the clinicians will be using the system day in and day out.

**Staff Training**

• Determine timelines for staff training. You will need a vendor that can provide ongoing staff training for regular intervals for several months.

• The vendor should also have readily available customer service support via phone or internet conferencing. Analyze what technical equipment you have and what equipment you may need to purchase to institute the new system.
Based on software demonstrations, proposals, and hours of analysis, you should now be able to make a final decision on your perfect EHR system.

Know that no EHR system will give you everything you desire. When you find a great system that meets the needs of your practice, you will likely have an issue with the cost being higher than you hoped.

Remember, you are looking for a system with a high value to your practice or clinic.

The EHR Contract

When you have identified your preferred vendor and determined they can meet your clinical system and training needs, you will need to create a software contract.

Your contract document must include information:

- pricing and payment plans
- number of users, locations
- billing specifications

Have your lawyers review the document for completeness and to ensure all specifications are met.

Once the software contract is complete and finalized, you can look forward to the next phase of your EHR journey; --- implementation.
EHR PREPARATION CHECKLIST

- Name a physician leader who will be responsible for EHR
- Determine levels of EHR access for staff
- Schedule a “go live” date during a slow period
- Set all goals backwards from the go live date
- Plan how to roll out your EHR (all at once or in sections)
- Get additional support from your vendor and REC
- Map our how your EHR fits into your workflow
- Plan how to migrate paper charts to EHR
- Gain in other physicians’ support via physician leader
- Set multiple staff training dates
- Identify hard infrastructure needs – printers, scanners, fax machines, etc.

Five Key Communication Behaviors

- Researchers at Kaiser Permanente have identified five key communication behaviors to foster smooth integration of computers into your practice:
  1. Let the patient look on
  2. Eye contact with the patient
  3. Value the computer as a tool
  4. Explain what you are doing
  5. Log off and say you are doing so

- The following charts provides a practical application for the five communication behaviors and details some recommended actions to use and scripts to say to effectively integrate the computer into your exam room interaction with your patient.

- By including a few new communication behaviors into everyday practice, a computer in the exam room will enhance the overall care experience for the patient.
## Practical Application for the Five Communication Behaviors

<table>
<thead>
<tr>
<th>Skills</th>
<th>Actions</th>
<th>What to Say</th>
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</table>
| Let the patient look on | • Move the screen for the patient to see.  
• Invite the patient to move closer to the screen to view information.  
• Ask the patient to verify information as you type.  
(This builds trust, actively involves the patient and demonstrates “we know you”) | • “Let’s look at the lab results to see how your cholesterol is doing.”  
• “Let me show you this part of the medical record so we can confirm some information together.”  
• “Here are the injections we have in our records. Have you had other injections outside this office that we need to add?” |
| Eye contact with the patient | • Greet the patient. Make a personal connection away from the computer.  
• Keep that connection throughout the visit:  
• Maintain eye contact.  
• Turn toward the patient when he/she speaks and during conversation.  
(Maintaining eye contact promotes active involvement) | • “Good morning, Mr. Jones. I see you hurt your ankle.”  
• “Let’s spend a few minutes discussing your options.” |
| Value the computer as a tool | • Acknowledge the computer.  
• Let the patient know how the computer improves care.  
• Stay positive when faced with computer challenges.  
(From the patient’s perspective, great medical technology is equated with great medical care.) | • “The computer makes getting and sharing information with other health care team members so easy and efficient.”  
• “This computer is great. I have all your background information at my fingertips – medications, prior visit notes and lab results.” |
| Explain what you are doing | • Keep the patient informed about your thought processes and actions.  
• As you are documenting, let the patient know what you are doing – entering information you have just discussed, ordering lab tests/medicines, accessing patient information.  
(Patients who receive no explanation about what you are doing may think you are working on unrelated business.) | • “I am printing some instructions, which we can go over together in a moment.”  
• “I am recording the details of your sore throat so our records will be complete.”  
• “I’ll order the medication we just discussed so it will be available at the pharmacy.”  
• “I’ll add the leg swelling to your problem list, so we can keep it in mind for future visits.” |
Log off and say you are doing so

Tell the patient that you are logging off the computer to safeguard his/her information. (Some patients are concerned about privacy and confidentiality. If their concerns are not addressed, satisfaction may decrease.)

“I am logging off the computer now to keep your information private.”

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**IMPACT OF MEANINGFUL USE**
Impact of Meaningful Use for Providers

- Clinical labs results
  - More than 458 million test results were entered into the EHR by 111,954 EPs

- Medication Reconciliation
  - Medication reconciliation was performed on 40 million patient transitions of care by 83,035 EPs

- Transition of Care Summary
  - More than 4.3 million patient transitions of care summaries were generated by 24,827 EPs

Because millions of lab results were entered into EHRs, millions of medication reconciliations were performed and millions of transitions of care summaries were generated, providers across the nation were able to access more information about their patients, better enabling them to provide care at the right time.
Real Impact of Meaningful Use for Patients

• **Electronic prescribing (eRx)**
  - More than 190 million electronic prescriptions have been sent by eligible professionals (EPs) for their patients.

• **Patient reminders**
  - More than 13 million patient reminders were sent for patients aged 65 or older 5 years of age or younger about preventive/follow-up care.

• **Patient electronic access**
  - More than 33 million patients received electronic access to their health information.

Impact of Meaningful Use on Public Health

Stage 2 will continue to encourage the transmission of data to registries and public health agencies to inform health care policy decisions, dive best practices, and improve our nation’s public health.

• **Immunization Data Submission**
  - Immunization registries received at least one test data submission from 69,474 EPs

• **Syndromic Surveillance Data Submission**
  - Public health agencies received at least one test data submission from 12,298 EPs
Tools, Tips, and Techniques

• Research EHR benefits/measures/objectives/incentives/penalties
• Conduct practice analysis
• Make a financial/patient-centered decision on implementation or not
• Select vendor
• Implementation checklist
• Train staff/adjust workflows, etc.

Resources

• https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/Payment-Adjustment-Information.html
• Quality Payment Program https://qpp.cms.gov
• EHR Selection Survival Guide http://specialreports.ehrinpractice.com/ehr-selection-survival-guide/?qclid=Cj0KEQiAuJXFBRDirlGnpZLE-N4BEiQAqV0KGrlvRkfJ_C0k-nFuSTpz0qcpcUaFTeZH76x0DZA-nRQaArZZ8P8HAQ
• Practice Management Institute
  www.pmiMD.com

Webinar/Audio Conference
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