Stanford HEALTH CARE

MU Stage 3 and HIE

Matthew Eisenberg, MD

SHC INFORMATION TECHNOLOGY SERVICES

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Meaningful Use Stage 3: Timing and Rule Making

STAGE OF MEANINGFUL USE CRITERIA BY FIRST YEAR

First Year as a Meaningful EHR User	Stage of Meaningful Use										
	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021 and future years
2011	1	1	1	2*	2	2	2 or 3	3	3	3	3
2012		1	1	2*	2	2	2 or 3	3	3	3	3
2013			1	1	2	2	2 or 3	3	3	3	3
2014				1	1	2	2 or 3	3	3	3	3
2015					1	1	1, 2 or 3	3	3	3	3
2016						1	1, 2 or 3	3	3	3	3
2017							1, 2 or 3	3	3	3	3
2018 and future years								3	3	3	3

*Please note, a provider scheduled to participate in Stage 2 in 2014, who instead elected to demonstrate stage 1 because of delays in availability of EHR technology certified to the 2014 Edition, is still considered a stage 2 provider in 2014 despite the alternate demonstration of meaningful use. In 2015, all such providers are considered to be participating in their second year of Stage 2 of meaningful use.

Meaningful Use Stage 3: Proposed HIE Changes

- **Objective 7: Health Information Exchange**
- Proposed Objective: The EP or hospital provides a summary of care record when transitioning or referring their patient to another setting of care, retrieves a summary of care record upon the first patient encounter with a new patient, and incorporates summary of care information from other providers into their EHR using the functions of CEHRT.

Meaningful Use Stage 3: Proposed HIE Changes

- Measure 1: For more than 50 percent of transitions of care and referrals, a summary of care record is **created and sent** electronically. **Stage 2 threshold was 50 percent for creation of summary of care record and 10 percent for electronic exchange.**
- Measure 2: For more than 40 percent of transitions and referrals **received** and patient encounters in which the provider has never before encountered the patient, incorporate into the patient's EHR an electronic summary of care document from a source other than the provider's EHR system.
- Measure 3: For more than 80 percent of transitions or referrals received and patient encounters in which the provider has never before encountered the patient, the EP, eligible hospital, or CAH performs a clinical information reconciliation that includes medications, medication allergy, and current problem list.
- Attest or Report numerators/denominators. Must meet 2 of 3 measures

Exclusions

- EP exclusion (Measure 1): An EP neither transfers a patient to another setting nor refers a patient to another provider during the EHR reporting period.
- Exclusion (Measures 2 and 3): Any EP or hospital for whom the total of transitions or referrals received and patient encounters in which the provider has never before encountered the patient, is fewer than 100 during the EHR reporting period.
- Additional exclusion (Measures 1, 2, and 3): Any EP that conducts 50 percent or more of his or her patient encounters in a county (or any hospital located in a county) that does not have 50 percent or more of its housing units with 4Mbps broadband availability according to the latest information available from the FCC at the start of the EHR reporting period.

Next Generation C-CDA R2.0

- CMS also notes that in the separately published 2015 Edition proposed rule, ONC is proposing a set of criteria called the Common Clinical Data Set (CCDS), which include the required elements for the summary of care document, the standards required for structured data capture of each, and further definition of related terminology and use.
- For Stage 3, CMS proposes that summary of care documents used to meet Objective 7 must meet the requirements and specifications included in the CCDS specified by ONC.
- CMS warns that the ONC proposal may include additional fields beyond those required for Stage 2 (e.g., a criterion and standard for capturing the unique device identifier (UDI) for implantable medical devices).

The Common Clinical Data Set includes key health data that should be exchanged using specified vocabulary standards and code sets as applicable

Patient name	Lab tests
Sex	Lab values/results
Date of birth	Vital signs
Race	Procedures
Ethnicity	Care team members
Preferred language	Immunizations
Problems	Unique device identifiers for implantable devices
Smoking Status	Assessment and plan of treatment
Medications	Goals
Medication allergies	Health concerns

ONC Interoperability Roadmap Goal

2015-2017

Send, receive, find and use a common clinical data set to improve health and health care quality.

Challenges for MU Stage 3 and HIE

- FAQ 9690 - If the receiving provider already has access to the CEHRT of the initiating provider of the transition or referral, simply accessing the patient's health information does not count toward meeting this objective
- Patient initiated referrals
- Ancillary providers and LTPAC facilities with no ability to receive DIRECT secure messages
- Storing and sending TWO versions of C-CDA
- IHE HPD standards for provider directories are immature and not fully adopted

IHE Healthcare Provider Directories (HPD)

IHE HPD Federated Provider Attributes

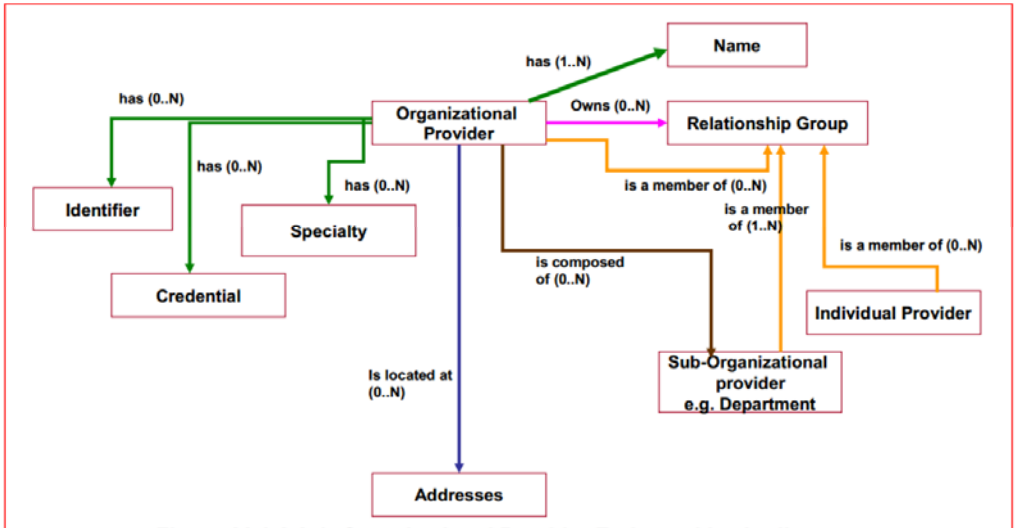

Figure 28.3.2.2-1: Organizational Provider Entity and its Attributes

13

Reconciliation Challenges

- Should reconciliation be automated or manual?
- Concern over the automatic inclusion of data in the patient record from referring providers but manual reconciliation imposes significant workflow burden
- The impact of the reconciliation requirement on workflow for specialists, and the specialties where this measure would be difficult to meet
- Whether the use and display of meta-tagged data could address concerns related to the origin of data and thereby permit more automated reconciliation
- Data provenance and the ability to filter for recent updates
- Whether the reconciliation (whether automated or manual) should only be performed by the same staff allowed under the Stage 3 requirements for CPOE