



CHCANYS DEFINING NEW DIRECTIONS
Community Health Care Association of New York State

NYS HCCN General Training: Meaningful Use in 2018 and HIE Optimization

Stephanie Rose, HealthEfficient

April 24, 2018





Agenda

- 1. Meaningful Use Program Basics**
- 2. Quick Review Modified Stage 2 for Payment Year 2018**
- 3. Meaningful Use Stage 3 Deep Dive (Optional 2018)**
- 4. HIE Optimization**
- 5. Q & A**



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MEANINGFUL USE PROGRAM BASICS

Stephanie Rose, MBA, CCE
Project Director



Medicaid Meaningful Use - Eligible Providers

- Physicians (M.D. and D.O.)
- Nurse Practitioners
- Certified Nurse Midwives
- Dentists
- Physician Assistants (only if they practice in an FQHC or RHC that is led by a PA)
 - EPs must demonstrate 30% or more Medicaid or Needy Patient volume in a 90 day period (20% for pediatricians)



Medicaid Incentive Payment

- Incentives paid over 6 participation years
- No Medicaid penalty for missing a year
- Payments
 - \$21,250 for Year 1 for Adopt, Implement Upgrade (AIU)
 - \$8,500 for Years 2-6 for Meaningful Use

Note: The last year to begin Meaningful Use was 2016



EHR Reporting in 2018

- All Eligible Providers demonstrating Meaningful Use can attest for a minimum of any continuous 90-Day Reporting Period for Objectives; and
- Attest to a minimum of any continuous 90-Day Reporting Period for Clinical Quality Measures in the calendar year.



Clinical Quality Measures (CQMs) for 2018

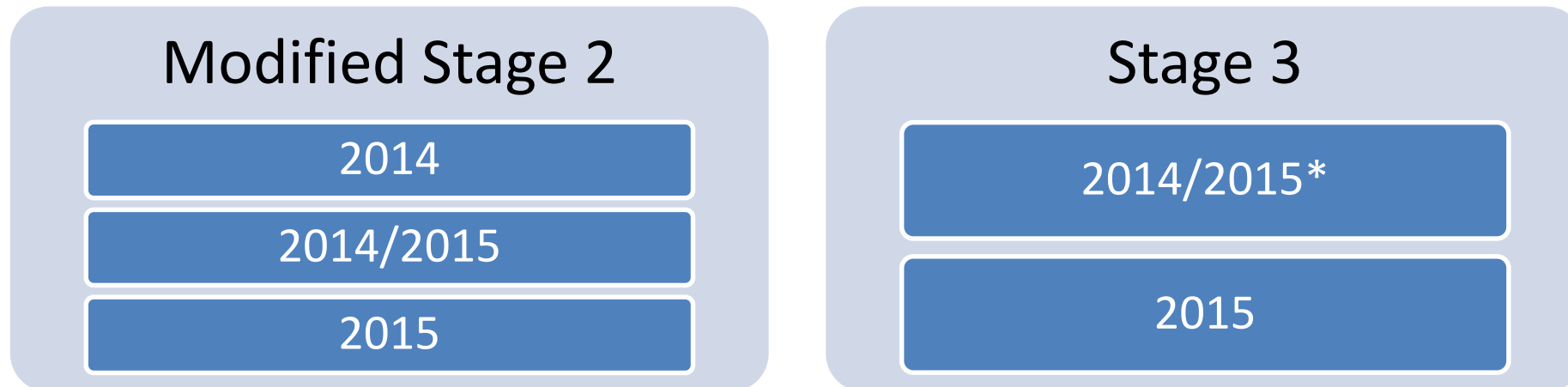
- Number of CQMs available reduced from 64 to 53 to match MIPS
- Attest to 6 CQMs (down from 9)
 - Across 3 domains

Engagement	Safety	Care Coordination
Population/Public Health	Resource Efficiency	Effectiveness



Certified EHR Technology (CEHRT) Requirement

- The 2017 CMS Final Rule allows all eligible providers to utilize:
 - 2014 Edition CEHRT
 - A combination of 2014 and 2015 Edition CEHRT
 - 2015 CEHRT





2018 Flexibility

- Eligible providers can meet either Modified Stage 2 or Stage 3 Requirements.
- If they are attesting to Stage 3, the CEHRT must meet all of the requirements for all of the Stage 3 Objectives.

Don't forget – this is the last quarter for 2017 Meaningful Use data. Don't miss out on your 2017 attestations!

First Year of MU	Stage of MU by Participation Year								
	2011	2012	2013	2014*	2015*	2016*	2017*	2018*	2019+
2011	AIU	1	1	2	Modified Stage 2	Modified Stage 2	Modified Stage 2 or Stage 3	Modified Stage 2 or Stage 3	Stage 3
2012		AIU	1	1	Modified Stage 2	Modified Stage 2	Modified Stage 2 or Stage 3	Modified Stage 2 or Stage 3	Stage 3
2013			AIU	1	Modified Stage 2**	Modified Stage 2	Modified Stage 2 or Stage 3	Modified Stage 2 or Stage 3	Stage 3
2014				AIU	Modified Stage 2**	Modified Stage 2	Modified Stage 2 or Stage 3	Modified Stage 2 or Stage 3	Stage 3
2015					AIU	Modified Stage 2	Modified Stage 2 or Stage 3	Modified Stage 2 or Stage 3	Stage 3
2016						AIU	Modified Stage 2 or Stage 3	Modified Stage 2 or Stage 3	Stage 3
2017	*2014, 2015, 2016, 2017 & 2018 Special 90 Day Reporting Period								



Medicaid Incentive Provider Payment Look-up Tool

- Medicaid EHR Incentive payment information beginning 2011 is available through [Health Data NY](#).
- Filter to find your provider/providers
- Ability to export data to a file

Provider Type	Eligible Practitioner First Name	Eligible Practitioner Last Name	Provider NPI	Payee NPI	Payment Date	Payment Amount	Payment Year	Participation Year	Provider Zip Code	County	Payee Name
PHYSICIAN	Sample	Provider	12345	67890	5/12/2014	\$8,500	2013	3	12477	Ulster	Sample Payee Name
PHYSICIAN	Sample	Provider	12345	67890	4/15/2013	\$8,500	2012	2	12477	Ulster	Sample Payee Name
PHYSICIAN	Sample	Provider	12345	67890	7/23/2012	\$21,250	2011	1	12477	Ulster	Sample Payee Name

<https://health.data.ny.gov/Health/Medicaid-Electronic-Health-Records-Incentive-Progr/6ky4-2v6j>



Provider Tracking Sheet

- Credentialing Information
- Attestation Tracking
- Budgeting

Provider Demographic Section							Participation Year 1			Participation Year 2			Participation Year 3		
First Name	Last Name	Suffix	Cred-ententials	Provider NPI	MU Eligible Provider (MD, DO, NP and PA*)	Status	AIU Reporting Year	AIU Submitted Date	AIU Received Date	Reporting Year	90 day Submitted Date	90 day Received Date	Reporting Year	Submitted Date	Receive
John	Test		MD		Yes	Active	2011	6/1/2011	9/1/2011	2012	4/1/2012	6/1/2012	2013	1/30/2014	
Jane	Test		NP		Yes	Active	n/a			2011	other practice	n/a	2012	1/30/2014	



Calculating Medicaid Eligibility Patient Volume

- 30% or more Medicaid patient volume during a 90 day period (20% for Pediatricians)
 - Standard Patient Volume:

$$\frac{\text{Total Medicaid Encounters}}{\text{Total Encounters}}$$

- Alternate Patient Volume:

$$\frac{\text{Medicaid Patient Panel} + \text{Medicaid Encounters}}{\text{Total Patient Panel} + \text{Total Encounters}}$$



Calculating Medicaid Patient Volume (cont)

- 90 Consecutive Days Options:
 - 90 days within the calendar year prior to the payment year, OR
 - 90 days preceding 12 months from the date of attestation
 - May use aggregate data from all providers at the practice
- ⚠ Use of the preceding 12 month option may delay payment due to availability of claims data



Needy Patient Option

- FQHC's and RHC's may use Needy Patients volume instead of the Medicaid volume.

Type of Service	Medicaid Volume	Needy Volume
Medicaid Fee-For Service	✓	✓
Medicaid Managed Care	✓	✓
Family Health Plus	✓	✓
Child Health Plus	✗	✓
Uncompensated Care	✗	✓
Sliding Scale	✗	✓



Prerequisites

Medicaid Fee For Service Provider Enrollment

Provider registered with CMS for the EHR Incentive

Link Provider to your ETIN

Provider has an ePaces user name and password

EHR Certification ID for eCW

NY Medicaid Pre-Validation

- Send the Excel [pre-validation file](#) to hit@health.ny.gov
- Information Required
 - Organization Name and NPI that the claims are billed under
 - Payment Year
 - Patient Volume Reporting Period Start/End Date
 - Group Medicaid Encounters
 - Group Total Encounters

Note: If you bill Medicaid under the provider NPI, you will need to complete the provider tab.



Meaningful Use MEIPASS Attestations

- 2017 Modified Stage 2/Stage 3 Attestation – not open
 - State has indicated this will be open soon but not date announced



MEDICAID MEANINGFUL USE QUICK REVIEW MODIFIED STAGE 2 IN 2018

Modified Stage 2 Pocket Guide – 2017 & 2018

Protect ePHI	Clinical Decision Support	Computerized Order Entry	Electronic Prescribing	Health Information Exchange
<p>Conduct or review a security risk analysis and address security including encryption</p>	<p>Implement 5 CDS Rules associated with 4 or more CQMS</p> <p>Enable drug/drug and drug/allergy checking</p>	<p>>60% of medication Orders entered using CPOE*</p> <p>>30% of lab orders entered using CPOE*</p> <p>>30% of diagnostic imaging orders entered using CPOE*</p> <p>*Exclusion <100 Orders</p>	<p>>50% of permissible prescriptions are queried for a drug formulary and transmitted electronically*</p> <p>*Exclusion <100 Prescriptions</p>	<p>>10% of transitions of care/referrals include a summary of care document created by the CEHRT and is exchanged electronically*</p> <p>*Exclusion <100 Transitions</p>
Patient Education	Medication Reconciliation	Electronic Access	Secure Messaging	Public Health/Clinical Data Reporting
<p>>10% of patients receive patient specific education resources identified by the EHR</p> <p>4/24/2018</p>	<p>>50% of transitions of care have the medications reconciled</p>	<p>>50% of unique patients seen by the EP are provided online access to view, download and transmit (VDT) within 4 business days;</p> <p>>5% View, Download, Transmit</p> <p>www.chcanys.org</p>	<p>>5% of patients was sent a secure message.</p>	<p>Active Engagement for 2 out of 3 registries</p> <ul style="list-style-type: none"> • Immunization (1x) • Syndromic (1x) • Specialized (2x) <p>Exclusion if registries outside scope or no registry available</p> <p>20</p>



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MEDICAID MEANINGFUL USE DEEP DIVE STAGE 3 IN 2018

Stage 3 Objectives 2018

Protect ePHI	Clinical Decision Support	Computerized Order Entry	Electronic Prescribing
<p>Conduct or review a security risk assessment and address security including encryption</p>	<p>Implement 5 CDSS Rules associated with 4 or more CQMS</p> <p>Enable drug/drug and drug/allergy checking</p>	<p>>60% of medication Orders entered using CPOE*</p> <p>>60% of lab orders entered using CPOE*</p> <p>>60% of diagnostic imaging orders entered using CPOE*</p> <p>*Exclusion <100 Orders</p>	<p>>60% of permissible prescriptions are queried for a drug formulary and transmitted electronically*</p> <p>*Exclusion <100 Prescriptions</p>
Health Information Exchange (Report all , meet 2 out of 3)	Electronic Access	Coordination of Care Patient Engagement (Report all , meet 2 out of 3)	Public Health/Clinical Data Reporting (Report 3 out of 5)
<p>>50% of transitions of care/referrals include a summary of care document created by the CEHRT and is transmitted electronically*</p> <p>>40% of transitions/referrals/ new patients received, the EP incorporates the summary of care into the EHR.*</p> <p>>80% of transitions/referrals/ new patients received have their medication, allergies, and problem list reconciled.*</p> <p>*Exclusion <100 Transitions</p>	<p>>80% of unique patients are provided online access to view, download and transmit their health information; AND ensures the information is available to access using an API</p> <p>>35% of patients seen by the EP are provided electronic access to patient-specific education resources</p>	<p>>5% * of unique patients see by the EP views, downloads, or transmits their health information; OR access their through an API; or a combination of the 2 options.</p> <p>>5% * of patients seen by the EP was sent a secure message</p> <p>>5% of patients seen by the EP have patient generated health data or data from a non-clinical setting is incorporated into the CEHRT.</p> <p>* thresholds increase in 2019</p>	<ul style="list-style-type: none"> • Immunization Registry • Syndromic Registry • Case Reporting • Public Health Registry** • Clinical Data Registry ** <p>** can have up to 2 different public health and clinical data registries each</p> <p>Exclusion if registries outside scope or no registry available</p>



OBJ 1: Protect ePHI – Attestation Measure

Objective: Protect electronic protected health information (ePHI) created or maintained by the CEHRT through the implementation of appropriate technical, administrative, and physical safeguards.

Modified Stage 2

Conduct/review security risk assessment and address security including encryption

Stage 3

Conduct/review security risk assessment and address security including encryption

Security Risk Assessment Tool: <https://www.healthit.gov/providers-professionals/security-risk-assessment-tool>



Protect ePHI Requirements

- Conduct/review security risk analysis of CEHRT including addressing encryption/security of data, and implement updates as necessary at least once each calendar year.
- Must be done upon installation or upgrade to a new system
- Security Updates and deficiencies identified should be included in the risk management process and implemented/corrected

HIPAA Security Rule Guidance: <http://www.hhs.gov/ocr/privacy/hipaa/administrative/securityrule/>



Threshold
Increase

OBJ 2: Electronic Prescribing (eRX)

Modified Stage 2

>50% of permissible prescriptions are queried for a drug formulary and transmitted electronically.

Stage 3

>60% of permissible prescriptions are queried for a drug formulary and transmitted electronically.

- More than 60% of all permissible prescriptions written by the EP are queried for a drug formulary and transmitted electronically using the CEHRT.

Exclusion: Providers that write less than 100 medication orders during the EHR reporting period or no pharmacies that accept electronic prescriptions within 10 miles of the practice.



OBJ 3: Clinical Decision Support (CDS) – Attestation Measure

Measure 1 - CDS Interventions



Modified Stage 2

Implement 5 CDS rules
associated to 4 or more
CQMs

Stage 3

Implement 5 CDS rules
associated to 4 or more
CQMs



CDS Measure 1 - Requirements

- Implement 5 clinical decision support interventions related to 4 or more Clinical Quality Measures (CQMs) at a relevant point in patient care for the entire EHR reporting period.
 - The same interventions do not need to be used for the entire reporting period, you just need to have 5
 - If there are limited CQMs for the EP, implement CDS interventions to drive improvements for high priority health conditions
 - Drug-drug and drug-allergy interaction alerts do not count towards the 5



OBJ 3: Clinical Decision Support (CDS) – Attestation Measure

CDS Measure 2 - Drug-Drug and Drug-Allergy

No
Change

Modified Stage 2

Enable drug-drug, drug-allergy
checking

Stage 3

Enable drug-drug, drug-allergy
checking

- Enable and implement the functionality for drug-drug and drug-allergy interaction checks for the entire EHR reporting period.

Exclusion: Providers that write less than 100 medication orders during the EHR reporting period.



OBJ 4: Computerized Provider Order Entry (CPOE)

Measure 1 - Medication Orders

No
Change

Modified Stage 2

>**60%** of Medication orders entered by a licensed healthcare professional using CPOE

Stage 3

>**60%** of Medication orders entered by a licensed healthcare professional using CPOE

- More than 60% of medication orders created by the EP during the EHR Reporting period are recorded using CPOE by a licensed or credentialed healthcare professional.

Exclusion: Providers that write less than 100 medication orders during the EHR reporting period.



OBJ 4: Computerized Provider Order Entry (CPOE)

CPOE Measure 2 - Laboratory Orders

Threshold
Increase

Modified Stage 2

>**30%** of Laboratory orders entered by a licensed healthcare professional using CPOE

Stage 3

>**60%** of Laboratory orders entered by a licensed healthcare professional using CPOE

- More than 60% of laboratory orders created by the EP during the EHR Reporting period are recorded using CPOE by a licensed or credentialed healthcare professional.

Exclusion: Providers that write less than 100 laboratory orders during the EHR reporting period.



OBJ 4: Computerized Provider Order Entry (CPOE) CPOE Measure 3 - Diagnostic Imaging Orders

Threshold
Increase

Modified Stage 2

>**30%** of Diagnostic Imaging orders entered by a licensed healthcare professional using CPOE

Stage 3

>**60%** of Diagnostic Imaging orders entered by a licensed healthcare professional using CPOE

- More than 60% of diagnostic imaging orders created by the EP during the EHR Reporting period are recorded using CPOE by a licensed or credentialed healthcare professional.

Exclusion: Providers that write less than 100 Diagnostic Imaging orders during the EHR reporting period.



OBJ 5: Patient Electronic Access to Health Information

Objective:

The EP provides patients (or patient-authorized representative) with timely electronic access to their health information and patient-specific education.



OBJ 5: Patient Electronic Access to Health Information

Measure 1 - Online Access

Modified Stage 2

>50% of unique patients are provided online access to view, download and transmit within 4 business days.

Stage 3

>80% of unique patients or authorized representative are provided online access to view, download and transmit their health information; AND ensures the information is available to access using an API.



Measure 1 - Online Access

- More than 80% of unique patients seen by the provider are provided timely access to view online, download, and transmit their health information within 48 hours of information being available; and
- The provider ensures the patient's health information is available to access using any application of their choice that meets the technical specifications of the Application Programming Interface (API).



OBJ 5: Patient Electronic Access to Health Information

Measure 2 - Patient Education

Modified Stage 2

> **10%** of patients receive patient specific education resources identified by the CEHRT

Stage 3

> **35%** of patients are provided electronic access to patient-specific education resources

- More than 35% of patients seen by the EP are provided electronic access to clinically relevant patient-specific educational resources identified by the CEHRT.



OBJ 6 - Coordination of Care

Objective:

- Use CEHRT to engage with patients or their authorized representatives about the patient's care.

Must report on all 3 measures but only need to meet the threshold for 2 of them.



OBJ 6: Coordination of Care

Measure 1 - Patient Engagement View, Download, Transmit (VDT)/API

Modified Stage 2

>5% of patients log on to the portal to view, download, transmit.

Stage 3

>5%* of unique patients seen by the provider views, downloads, or transmits their health information; OR access their health information through an API; or a combination of the 2 options.

*Stage 3 reporting in 2019 and subsequent years: threshold increases to >10%



The following must be available for the patient to View, Download, Transmit or access with an API within 4 business days:

- Patient name
- Provider's name and office contact information
- Current and past problem list
- Procedures
- Laboratory test results
- Current medication list and medication 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, including goals and instructions
- Any known care team members including the primary care provider (PCP) of record



Threshold
Increase

OBJ 6: Coordination of Care

Measure 2 - Secure Electronic Messages

Modified Stage 2

>5% of patients were sent a secure electronic message using the electronic messaging function of the CEHRT to the patient or in response to a secure message sent by the patient.

Stage 3

>5% * of patients were sent a secure electronic message using the electronic messaging function of the CEHRT to the patient or in response to a secure message sent by the patient.

*Stage 3 reporting in 2019 and subsequent years: threshold increases to >25%



OBJ 6: Coordination of Care

Measure 3 - Patient Generated Data (New)

Modified Stage 2

Stage 3

>5% of patients seen by the provider have patient generated health data or data from a non-clinical setting is incorporated into the CEHRT.



OBJ 7: Health Information Exchange (HIE)

Objective:

The EP provides a summary of care record when transitioning or referring their patient to another setting of care, receives or retrieves a summary of care record upon the receipt of a transition or referral or 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.

Must report on all 3 measures but only need to meet the threshold for 2 of them



Threshold
Increase

OBJ 7: HIE

Measure 1 - Summary of Care (Outbound)

Modified Stage 2

> **10%** of transitions of care/referrals include a summary of care document created by the CEHRT and is exchanged electronically.

Stage 3

> **50%** of transitions of care/referrals include a summary of care document created by the CEHRT and is exchanged electronically.

Exclusion: Provider that refers/transfers patients to another provider less than 100 during the EHR reporting period.



Summary of Care Requirements

- Patient name
- Referring or transitioning provider's name and office contact information
- Procedures
- 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
- Reason for referral
- Current verified problem list
- Current verified medication list
- Current verified medication allergy list www.chcanys.org



OBJ 7: HIE

Measure 2 - Summary of Care (Inbound)

Modified Stage 2

Stage 3

>40% of inbound transitions, referrals, or new patients, the provider incorporates the patient's summary of care record into the EHR.

Exclusion: Provider that receives less than 100 transitions, referrals and new patients during the EHR reporting period.



Measure 2 – Calculation

Numerator: Number of patient encounters in the denominator where an electronic summary of care record received is incorporated into the CEHRT.

Denominator: Number of patient encounters during the EHR reporting period for which an EP was the receiving party of a transition or referral or has never before encountered the patient **AND for which an electronic summary of care record is available.**



OBJ 7: HIE

Measure 3 - Reconcile Clinical Information

Modified Stage 2

>**50%** of transitions of care have the medications reconciled.

Stage 3

>**80%** of transitions, referrals, and new patients have their medication, allergies, and problem list reconciled.

Exclusion: Provider that receives less than 100 transitions, referrals and new patients during the EHR reporting period.



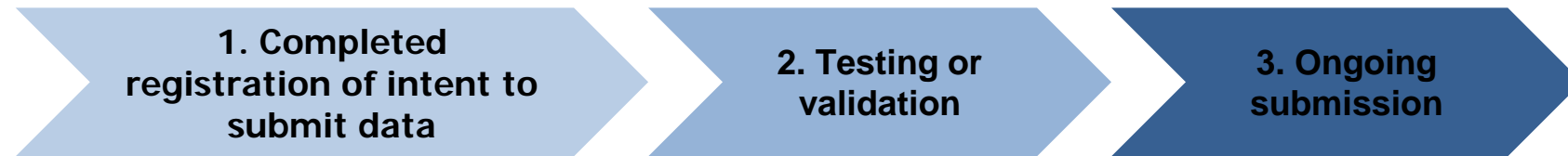
Measure 3 – Calculation

Numerator: The number of transitions of care or referrals in the denominator where the following three clinical information reconciliations were performed: medication list, medication allergy list, and current problem list.

Denominator: Number of transitions of care or referrals during the EHR reporting period for which the EP was the recipient of the transition or referral or has never before encountered the patient.



OBJ 8: Public Health/Clinical Data Reporting



Public Health Measures		Requirement
1	Immunization Registry	Bi-directional data exchange proposed
2	Syndromic Surveillance	EPs report data from non-urgent care ambulatory settings; EHs from emergency or urgent care departments
3	Case Reporting <i>(expanded cancer reporting)</i>	"Reportable conditions" as defined by state, territorial, or local public health agencies (PHA)
4	Public Health Registry	Registry administered by, or on behalf of, a local, state, territorial, or national PHA
5	Clinical Data Registry (CDR) <i>(formerly specialized registry)</i>	Registry administered by, or on behalf of, non-public health agency entities; Includes Cancer Registry for EPs only
<i>Must attest to 3 out of 5 Measures.</i>		



Stage 3 - Public Health Options

Stage 3

Eligible Professionals		
Public Health Reporting Measure	5 Boroughs of NYC	NYS (Excluding the 5 Boroughs of NYC)
Immunization Registry Reporting	Citywide Immunization Registry (CIR)	NYS Immunization Information System (NYSIIS)
Syndromic Surveillance Reporting	NYC Department of Health and Mental Hygiene (NYC DOHMH)	NYS Department of Health (NYSDOH)
Electronic Case Reporting	NYC DOHMH Electronic Case Reporting Registry (ECR)	NYSDOH Electronic Case Reporting (eCR) Registry
Public Health Registry Reporting – Cancer Case Reporting	NYS Cancer Registry (NYSCR)	
Specialized Registry Reporting – Population Health Reporting	Population Health Registry*	Not available to EPs outside of NYC

* For Meaningful Use Stage 3, the Population Health Reporting Registry is only available via the [Public Health Reporting Grandfathering Regulation](#)

https://health.ny.gov/health_care/medicaid/redesign/ehr/publichealth/2018_phr.htm



AHRQ Registry of Patient Registries

- <https://patientregistry.ahrq.gov/>
- Allows you to search for patient registries you can use

U.S. Department of Health & Human Services www.hhs.gov

AHRQ Agency for Healthcare Research and Quality
Advancing Excellence in Health Care www.ahrq.gov

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RoPR | REGISTRY of PATIENT REGISTRIES

HOME SEARCH STRUCTURED SEARCH SIGN IN

SEARCH Enter a word or make selections to narrow search results

Current Filter Selections
Add filters to narrow search results.

Filter By:

Classification *
--Select--

Purpose *
--Select--

Geography
--Select--

Interested in Being Contacted
--Select--

Reasons for Being Contacted *
--Select--

Has Progress Report *
--Select--

Condition of Interest *
--Select--

Category of Interest *
--Select--

* Search criteria marked with an asterisk filters from a subset of those registries that were directly added to the RoPR System.

Enter search term... Search

Add search terms for relevant results. config

< 1 2 3 ... 381 382 > displaying 1 to 10 3812 results

Comparative Effectiveness of Treatment Strategies for Primary Open-Angle Glaucoma (RiGOR)
Registry Classification: Disease/Disorder/Condition; Service, Procedure
Registry Purpose: Effectiveness; Public Health Surveillance
Last Updated On: July 10, 2014
Brief Description: The primary objectives of the study are: 1. To compare the proportion of patients who achieve a successful response to treatment (reduction in Intraocular Pressure (IOP) of >15%) between pa...

Sleep-Disordered Breathing in Heart Failure - The SchlaHF-Registry
Registry Classification:
Registry Purpose:
Last Updated On: August 4, 2015
Brief Description: Objective target of the registry is to investigate the prevalence of SDB as well as the clinical characteristics of patients with and without SDB as well as the predominant type of sdb. For ...

Cortico-saving Treatments Proposed for CLIPPERS: a First Cohort
Registry Classification: Disease/Disorder/Condition



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Community Health Care Association of New York State



REGIONAL EXTENSION CENTER SUPPORT

Upstate – New York eHealth Collaborative (NYeC)

NYC – NYC Reach



NYeC EP2: Eligible Professional Program

- EP2 is a state funded grant program that is designed to provide free consulting services to providers who are participating in the New York State Medicaid EHR Incentive program
- Along with our subcontractors who are strategically placed throughout the state, NYeC can help your practice achieve various stages of Meaningful Use
- In-person and web-based education events hosted quarterly to discuss best practices and keep you up to date on the MU objectives
- This program is slated to run from 2018-2022



NYeC EP2 Program Milestones

NYeC will offer continuous assistance throughout your Medicaid EHR participation. Program milestones are tied to each Meaningful Use attestation you complete each year.

- Milestone 1: Successful attestation to Meaningful Use Stage 2 (including modified Stage 2) for the provider's first time
- Milestone 2: Successful second or subsequent attestation to Meaningful Use Stage 2
- Milestone 3: Successful attestation to Meaningful Use Stage 3 for the provider's first time
- Milestone 4: Successful second or subsequent attestation to Meaningful Use Stage 3

*Please note that successful attestation means the provider is paid for MU in that particular payment year.



NYeC EP2 Enrollment

- Agent contacts Practice
- Practice Sign Up with the Regional Extension Center Agent
 - Sign Provider Participation Agreement prior to PY 2017 MU Attestation
- Attest for PY 2017 MU and beyond





IMPROVING TRANSITIONS OF CARE AND CARE COORDINATION

Health Information Exchange



Definitions

Transition of Care: Movement of patients between health care locations, providers, or different levels of care. Set of actions designed to ensure coordination and continuity of care based on current information about the patients treatment goals, preferences and health status.

Care Coordination: Deliberate organization of patient care activities among two or more participants, which includes the patient and/or their family, to facilitate appropriate delivery of healthcare services.



Barriers

- Lack of Information
- Lack of communication
- Siloes of information
- Delays in receiving information



RHIOs in New York State

Rochester RHIO:

200 Canal View Blvd., Suite 200
Rochester, NY 14623
Jill Eisenstein:
jeisenstein@grrhio.org
877-865-7446
<http://www.grrhio.org>

HealtheConnections:

109 South Warren Street
State Tower Building, Suite 500
Syracuse, NY 13202
support@healtheconnections.org
315-671-2241
<http://www.healtheconnections.org>

Health Information Xchange New York (HIXNY):

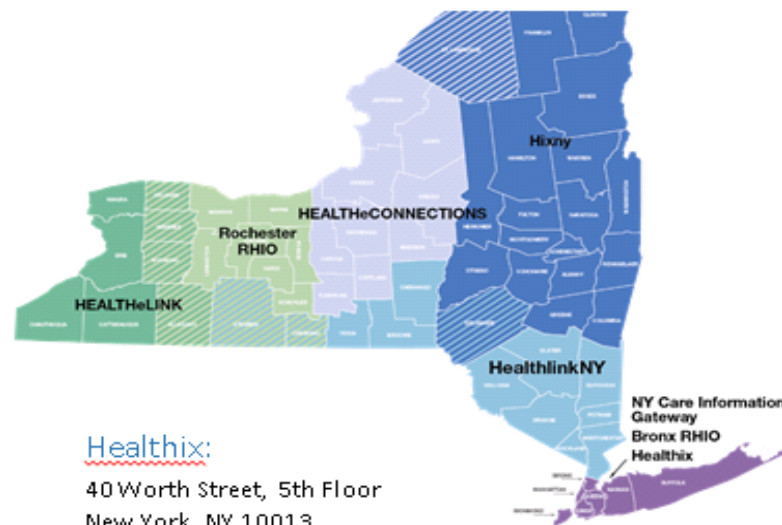
15 Cornell Road, Latham, NY
12110
info@hixny.org
518-783-0518x28
<http://www.hixny.org>

HealthlinkNY:

West Office:
49 Court Street, Suite 300,
Binghamton, NY 13901
East Office:
300 Westage Business Center
Drive
Suite 150, Fishkill, NY 12524
Christina Galanis:
cgalanis@healthlinkny.com
(844) 840-0050
www.healthlinkny.com

HEALTHeLINK

2568 Walden Avenue, Suite 107
Buffalo, New York 14225
716-206-0993x311
Dan Porreca:
dporreca@wnyhealthelink.com
<http://wnyhealthelink.com>



Bronx RHIO:

2275 Olinville Ave.,
Bronx, NY 10467
Charles Scaglione:
cscaglio@bronxrhio.org
718-708-6633
<http://www.bronxrhio.org>

Healthix:

40 Worth Street, 5th Floor
New York, NY 10013
Tom Check:
tcheck@healthix.org
877-695-4749x1 www.chcanys.org
<http://healthix.org>

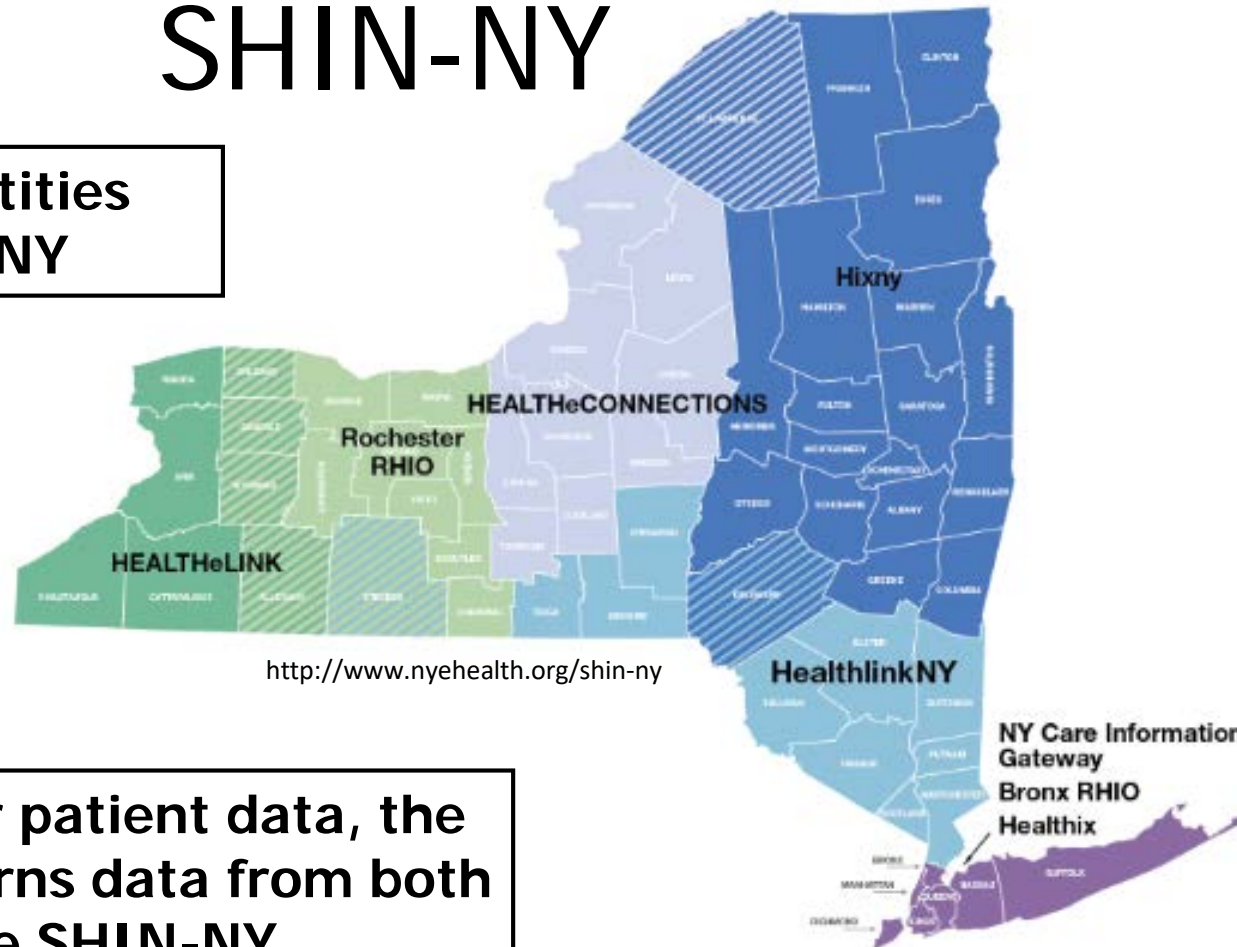
NY Care Information Gateway:

P.O. Box 800038
Elmhurst, NY 11380
Flowerfield Industrial Park,
Building 7, Suite 44,
Saint James, NY 11780
Al Marino:
al.marino@interbororhio.org
718-334-5844
Sue-Ann Villano:
sue-ann.villano@stonybrookmedicine.edu
631-638-4000
<http://nycig.org>



SHIN-NY

**8 HIEs or Qualified Entities
compose the SHIN-NY**



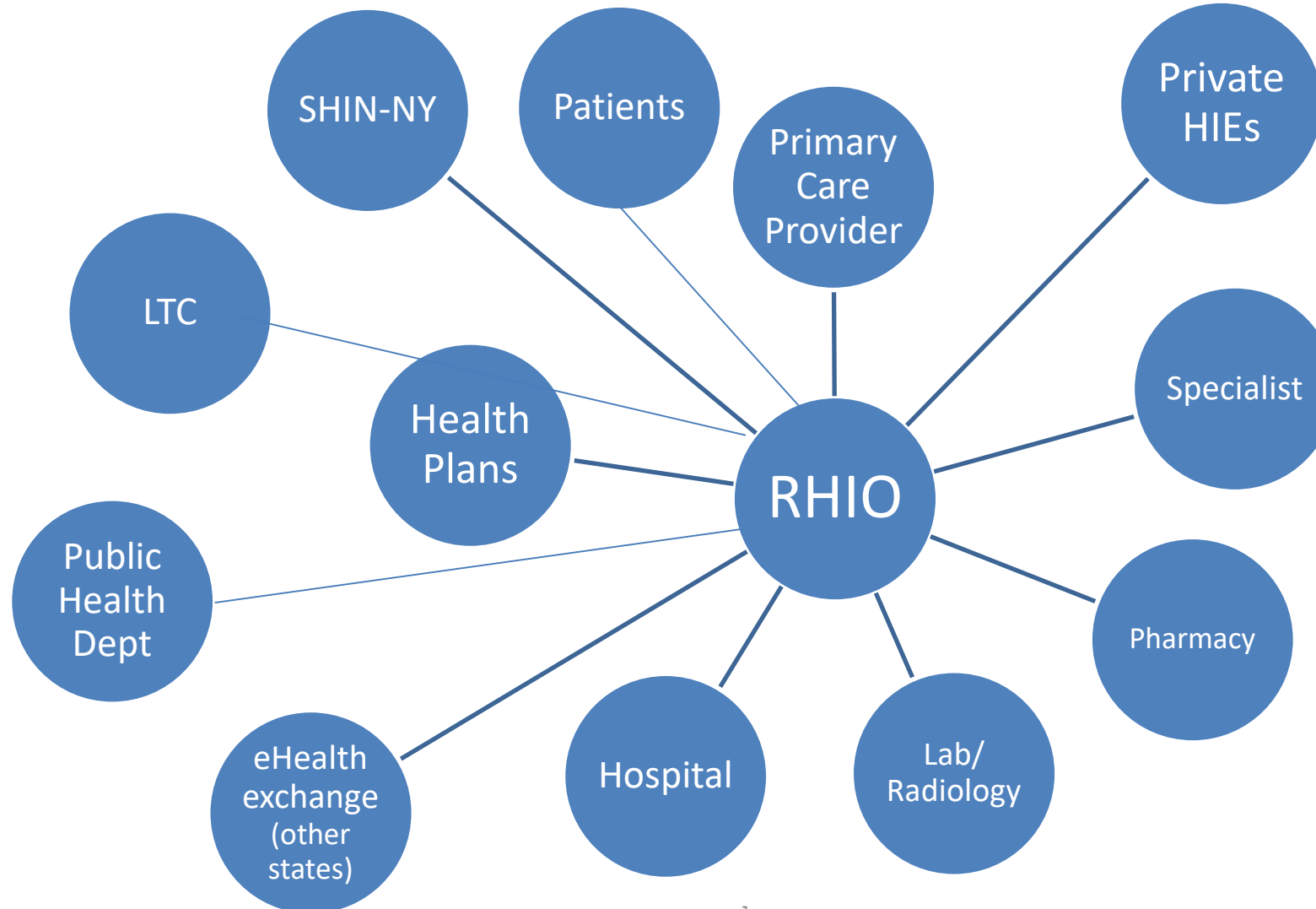
<http://www.nyehealth.org/shin-ny>

**When a user queries for patient data, the
RHIO automatically returns data from both
the RHIO and the SHIN-NY**



What are the RHIO benefits?

- Supplies secure data to improve healthcare quality, efficiency and effectiveness
- Provides a range of clinical information in real-time
- Improved coordination of patient care
- Fewer repeated medical tests and procedures
- Better emergency care for patients





Types of Data Generally Available through HIE

- Demographics
- Allergies
- Medications
- Diagnoses/Problem lists
- Advance directives
- Encounters
- Observations
- Care Plans
- Lab results
- Ultrasound reports
- Radiology reports
- Respiratory results
- Surgical notes
- Clinical summaries
- Discharge summaries



Patient Consents

New York State consent model:

- Patient consent is not needed for participant organizations to provide patient data to HIE
- Patient consent is needed for participant to access data
- A recent change in NYS Policy allows clinical alerts to be sent to a provider with essential patient data only without requiring patient consent. Additional information is provided based on patient consent.
- Emergency providers can access data without consent in some circumstances



HIE Tools

- View of longitudinal aggregated patient health record
- Directory of providers and where the patient has received care
- In Patient Hospital/Emergency Department Alert notifications
- Electronic referrals
- Communication (secure messaging)



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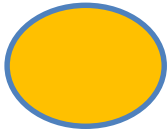


WORKFLOWS

Sample



Clinical Event Notifications



Determine what types of event notifications you want



Case Manager (RN) review discharge notifications for Emergency Department, Outpatient and Inpatient, etc.



Make follow-up appointments for patients by phone or e-message (portal)



Possible Care Coordination Teams

- RN Lead
 - Case Managers
 - Social workers
 - Receptionist
 - Behavioral Health
 - MA

RN reviews notification
and assigns to
appropriate team
member for follow up



Pre-Visit Planning or During Appointment



Registration staff obtain patient RHIO Consent and link patient to the RHIO.



Provider/Nurse pulls up patient summary through RHIO portal view or within the EHR.



Review aggregate data and update patient chart with relevant information. (manually or integrated functionality in EHR)



Electronic Referrals



Provider refers the patient to a provider that has a “direct” address that can accept electronic referrals.



Referral Staff send the referral electronically with a Summary of Care/CCDA document generated by the EHR attached.



Referral provider receives the referral in their EHR with all relevant information provided by the CCDA.



Patient Electronic Access View, Download, Transmit



Eligible Provider's Patient signs up for portal access through the RHIO that is certified on the CCHIT site for this objective.



Patient logs on to the certified RHIO portal to view download transmit.



Eligible Provider receives report from the RHIO of electronic access VDT measure.



Nationwide Exchange Frameworks



Registration staff obtain patient Framework Consent.

Query sent to appropriate framework to look for a patient match when patient check in.

Clinical Documents (CCDAs) are displayed in the EHR and can be pulled into the EHR.



Access to Notifications

Review Documents

Outstanding | Reviewed | All | All Outstanding

Assigned to: HospitalDischarges, Hometown | Facility: | All | Scanned by: All

<input type="checkbox"/>	Scan Date	Patient Name	Custom Name	Assigned To	Description
<input type="checkbox"/>	04/05/2017		Exch-an-ge 00:00:00_Exchange N	HospitalDischarges, I	Electronic document received from HIXNY
<input type="checkbox"/>	04/05/2017		Exch-an-ge 00:00:00_Exchange N	HospitalDischarges, I	Electronic document received from HIXNY
<input type="checkbox"/>	04/05/2017		Exch-an-ge 00:00:00_Exchange N	HospitalDischarges, I	Electronic document received from HIXNY
<input type="checkbox"/>	04/05/2017				Electronic document received from HIXNY
<input type="checkbox"/>	04/05/2017				Electronic document received from HIXNY
<input type="checkbox"/>	04/05/2017				Electronic document received from HIXNY
<input type="checkbox"/>	04/05/2017				Electronic document received from HIXNY
<input type="checkbox"/>	04/05/2017				Electronic document received from HIXNY

Patient Acct#: Patient MR#: Source Facility: Ellis Medicine

Patient Phone Number:

Patient Reported Primary Care Provider:

ADM-ClinicianName Code AA
Emergency Doctor
AdmitDateTime: 2017-04-04 22:42:00 DischargeDateTime: 2017-04-05 00:23:00

ATT-ClinicianName Code AA
Emergency Doctor
AdmitDateTime: 2017-04-04 22:42:00 DischargeDateTime: 2017-04-05 00:23:00

Admit Reason Description: Bilateral flank pain

AllergenType	ID	Desc	SeverityCode	ReactionCode	IDDate
No Allergy Found					

DiagnosisCode



Access to Patient Summaries

eClinicalWorks (Willis,Sam,Multi)

File Patient Schedule EMR Billing Reports CCD Fax ePayment Tools Community Lock Workstation Help

eClinicalWorks S 0 D

Admin
Practice

Progress Notes

Sardell, John , 85 Y, M Sel Info Hub

123 First St
Brooklyn, ny 94544
DOB:01/01/1925
eHX Status: ✔

Allergies
Billing Alert

Wt 09/10/10: 44 lbs.
Appt(L): 09/10/10
Language: No
Translator: No

Ins: Self Pay
Acc Bal: \$0.00
Guar: test test
Gr Bal: \$0.00

CLICK TO EDIT

SECURE NOTES

ADV DIRECTIVE

Medical Summary | CDSS | Labs | DI | Procedures | Growth Chart | Immunization | Encounters | Patient Docs | Flowsheets | Notes | **Patient External Documents**

SF [dropdown]

Patient Hub (Sardell, John)

Rel [dropdown] Default [dropdown] Encounter [dropdown]

Overview DRTL Hist

Patient: Sardell, John

Sardell, John
123 First St
Brooklyn, ny-94544
DOB: 01/01/1925
Age: 85 Y Sex: M
Advance Directive:
eClinicalMessenger Enabled: No
Account No: 9140

Home:
Work:
Cell:
Email:
Insurance:
PCP:
Rendering Pr:

Patient Balance: \$0.00
Account Balance: \$0.00
Collection Status:
Assigned To:

Last Appt: 09/10/2010 08:30 AM
Next Appt:
Bumped Appts: NONE

Facility: NYHDOHMH-EMR1 FACILITY
Facility:
Case Manager Hx:

New Appt	New Tel Enc	Print Label	Billing Alert	Patient Docs
Letters	Encounters	Medical Summary	Rx	Progress Notes
eClinForms	Devices	Problem List	Medical Record	Send eMsg
Account Inquiry	Guarantor Bal.	Consult Notes	Letter Logs	Fax Logs
New Action	Flowsheets	eMessenger	Billing Logs	
eHX Consent	Export eHS	Export Labs	Export Documents	

Patient External Documents [Close]

2. Access from Patient Hub window



Import Documents

Patient Documents

Import Documents | All | Labs | Scanned Documents | Medical Summary | PHR

test, pcip09161 (Global Id: 6775) Between 06/19/2010 ... And 09/15/2010 ...

Import to EMR | Documents 1 to 1 of 1

Document Name Creation Date Document Type

Patient Detail Aggregated CCD

Last refresh was done on Fri, 17 Sep 2010 10:33:50 AM EDT **Refresh External Data**

Patient Documents

Import Documents | All | Labs | Scanned Documents | Medical Summary | PHR

test, pcip09161 (Global Id: 6775) Between 06/19/2010 ... And 09/15/2010 ...

Import to EMR | Documents 1 to 1 of 1

Document Name Creation Date Document Type

Patient Detail Aggregated CCD

Last refresh was done on Fri, 17 Sep 2010 10:33:50 AM EDT **Refresh External Data**

June 2010						
Su	Mo	Tu	We	Th	Fr	Sa
30	31	1	2	3	4	5
6	7	8	9	10	11	12
13	14	15	16	17	18	19
20	21	22	23	24	25	26
27	28	29	30			

Interfaces with Healthix do not support a date range query. The document will always display all available clinical data.



View Patient eHealth Summary

The screenshot shows a web application window titled "Patient Documents". It features a navigation bar with tabs for "All", "Labs", "Scanned Documents", "Medical Summary", and "PHR". Below the navigation bar, there is a search filter for "test, pcip09161 (Global Id: 6775)" with a date range "Between 06/19/2010 ... And 09/15/2010". A table lists documents with columns for "Document Name", "Creation Date", and "Document Type". The "Patient Detail" document is highlighted with a red box. At the bottom of the window, there is a "Refresh External Data" button and a note: "Information within the Patient eHealth Summary".

- Patient
- Author
- Custodian
- Encounter
- Advanced Directives
- Problems
- Allergies, Adverse
- Reactions, Alerts
- Family History
- Social History
- Medications
- Immunizations
- Vital Signs
- Results
- Procedures
- Encounters



Patient Summary Document

The screenshot shows a web browser window titled "Patient Summary Document - Windows Internet Explorer". The page displays patient information and clinical sections. The patient information includes MRN: 7082, Sex: Male, Birthdate: , Address: 101 smith st, Brooklyn, ny, 11217, and Next of Kin: Guardian: . Below this, there are sections for AUTHOR and LEGAL AUTHENTICATOR, both with fields for Author, Telecom, Address, and Organization. The CUSTODIAN section lists Name: BHIX, Address: 1045 39th Street, Brooklyn, NY, 11219, and Telecom: tel:(718) 283-5650. The ENCOMPASSING ENCOUNTER section has From: , To: , and a TABLE OF CONTENTS. The TABLE OF CONTENTS lists: [Allergies, Adverse Reactions, Alerts](#), [Medications](#), [Immunizations](#), [Vital Signs](#), and [Procedures And Interventions](#). Below the table of contents, there is a section for [Allergies, Adverse Reactions, Alerts](#) with a table header: Allergy Name, Allergy Type, Status, Severity, Reaction(s), Onset Date.

The table of contents lists each clinical section of the eHS that is included for your patient. Click on a link to take you directly to a specific section.



Import Patient eHealth Summary into your EMR

The screenshot shows a software window titled "Patient Documents" with a close button (X) in the top right corner. Below the title bar is a navigation bar with tabs: "Import Documents", "All", "Labs", "Scanned Documents", "Medical Summary", and "PHR". The "Import Documents" tab is active. Below the navigation bar, the patient ID "test. pcip09161 (Global Id: 6775)" is displayed. To the right, a date range filter is set to "Between 06/19/2010 ... And 09/15/2010 ...". Below this, there is a button labeled "Import to EMR" which is highlighted with a red box. Below the button is a table with columns "Document Name", "Creation Date", and "Document Type". The table contains one row: "Patient Detail" with "Aggregated CCD" as the document type. This row is also highlighted with a red box. At the bottom of the window, there is a status bar that says "Last refresh was done on Fri, 17 Sep 2010 10:33:50 AM EDT" and a button labeled "Refresh External Data".



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ANNOUNCEMENTS

Barb

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CALL FOR ABSTRACTS AT CHCANYS ANNUAL CONFERENCE

- CHCANYS Annual Conference is October 21st- 23rd in Tarrytown, NY!
- We are open for abstract submissions for workshops and posters. The submission deadline is May 15th. More information can be found here:

<http://www.chcanys.org/>



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Questions?





SURVEY LINK

<https://www.surveymonkey.com/r/9B5KD6P>