This transcript is intended to provide webinar content in an alternate format to aid accessibility. We apologize for any inaudible or unclear content as a result of audio quality.

**Learning and Action Network State Meaningful Use: Understanding the Changes for the EHR Incentive Program**

Presented by Paul Kleeberg, MD, FAAFP, FHIMSS, CMIO (60-minute webinar)

Please standby for realtime transcript.

Good afternoon, ladies and gentlemen, thank you for waiting. Welcome to the stage 2 meaningful use understanding the changes for the EHR incentive conference call. All lines are placed on listen-only mode and the floor will be open for questions and comments following the presentation. It is my more to -- pleasure to turn the floor over to your host.

Thank you very much. Welcome, everyone, to the fifth webinar in the series of the webinar sponsored by reach, the states of Minnesota and North Dakota. As you heard, we will be looking at the changes for the EHR incentive program for the stage 2 meaningful use. Dr. Paul Kleeberg will be our presenter today. We will open the lines for questions periodically throughout the program today. Otherwise, your lines will be muted. Also, if you want to ask questions via the chat function, you can do that. With that, I am going to turn the program over to Dr. Paul Kleeberg. It's yours.

Thank you, Gini. Good noon, everyone. I am speaking to you from warm Washington, D.C. Ironically, it's in the 60s here the last few days. I have been down here at a mobile health conference, and there are interesting things happening to help manage patients and connect patients with electronic health records and also to keep them with their providers and to keep patients at home -- at home as they begin to age. I think we'll begin to see more and new innovative things coming as the accountable care organizations and we switch or payment and intervention-based payment plan to one where people are kept healthy. So, today, we're going to talk about the changes in the EHR incentive program in stage 1 and stage 2 so that you can begin to know some of what you need to do to meet the requirements and how this will affect you, your staff, and your workflow. First, just changes to the timeline. I think you have seen this grid before. It bears some explanation. The numbers on this grid really have no bearing on whether or not you have done adopt implement and upgrade. When you get that, that is basically a, does not tie out the timeline. But when you attest to meaningful use, the first time you attest, that starts your clock. If you go down the left-hand column, you will see your first year of a testation and then what -- attestation and what stage of meaningful use you will need to be along that process. For example, if you first attested meaningful use in 2013 for 90 days, you would then again do a full year of meaningful use, you would continue to do stage 1 in 2014 and then switch to stage 2 in 2015. This is regardless of whether or not you achieve the meaningful use quality, or I should say the measures for any particular instance. For example, if you skip a year under Medicare because you're unable to attest or under Medicaid because you chose not to attest, this timeline
keeps Marching forward. Something to be aware of. Also, you can see whenever you start from 2011 to 2013, you're at stage 1 and that is just 90 days. Just to open the line for a SEC. Any questions on that one? Okay. Hearing nothing, each time we come to this outline, I will open the lines for folks to ask questions and can you put them in the chat, if you would. So, let's now talk about the certification standards for software. The certification standards, the original ones were in 2011. They were only supposed to be good for 2011 and 2012, but now they're good all the way through 2013. There are new certification standards for 2014 and every one is going to need to have 2014 certified software for the 2014 payment year. So that means hospitals will need to have them in place as of October of this year. I am certain I thought October of 2013. I keep thinking it's between the 39 2013. We have to wait a few more days. The good news about this is that it's not a one-size-fits-all product that you have, you need to purchase what you need to achieve meaningful use.

I'm sorry?

This is an example of what it looks like today. One size, if none, so to speak, I think the fonts have changed a bit since it was uploaded, and -- Oh. It didn't build. This is what it's going to look like in 2013. -- 2014. This is interesting. The slides are not buildings way I would have expected here. If you look at the bullet in the center, that is what we call the base EHR. The base EHR has the basic functionality that is defined by statute to have things like CPOE, demographics, the ability to report quality measures, security and privacy and a couple of other very basic elements. The core layer is a layer which stands for what stage of meaningful use you're at or as the menu lay cert layer that you, includes the menu items and quality measures that you will choose to select. So, let's see what happens here. None of the slides, that is interesting. I'm not sure why this is not showing. So this slide would actually show you what was in the base EHR. Those things that I mentioned. I will also mention and it will occur later as well that because everyone needs to upgrade to 2014 certified software, in 2013 and 2014, you will have a break and that year and that year only, you will not need to do an entire year of meaningful use. You will need to demonstrate meaningful use for just one quarter during that year. By one quarter, it would be for providers January 1-March 31st, et cetera. Any questions at this point? Let's open the lines for a moment?

All lines are unmuted.

Can you clarify if -- did you just say in 2014 is when we only need to do 90 days or -- because next year's the whole year, if I remember right, for participating providers already.

That's correct. This next year is a whole year and because everyone at both stage 1 and stage 2 is going to need to be on 2014 certified software, they have changeed that year and that year only, so everyone only needs to report a quarter. Not 90 days, but a quarter. The difference between stage 1 year first year is the sliding 90-day period of any point in time. If it's your first year in 2014, it would still be a sliding 90 day. For everyone else, it would be a quarter for reporting.

Okay. Thank you.

Okay. Let's talk about -- [ Indiscernible ]

Just a quick question on that. When you say a sliding quarter, is it a calendar quarter or could it go from, you know, February, March, April, or does it have to be like January, February, March?
It has to be January, February, March.

Okay. Thanks. Or April, May, June and for hospitals, it could be October, November, December. Okay. Let's talk about the new requirements and options for stage 1. Oh, my gosh. All of these slides aren't showing.

I'm sorry?

Are you on the call? I'm trying to get a hold of the person from buccaneer. Okay. Is there someone -- just a minute. Just hang on, Paul. We're going see if we go can get the slides reloaded. Is the person from Buccaneer on?

I'm really sorry about this, folks. I am not sure why this stuff is not appearing. Apparently it was tested in advance, but -- .

Here, let's -- we're calling the people who are hosting the webinar right now, Paul.

Okay.

So let's let me just speak. While they calling, let me speak from -- maybe I will speak from my own slides. If I can get them up here quickly, at least if I can talk.

The only changes in stage 1 and stage of meaningful use and the most important one has to do with exclusions. For the menu item exclusions previously you would still be able to defer five items in addition to any that you excluded. So, conceivably, if a person had five exclusions, they would not have to report any menu items. That is no longer the case starting in 2014. You now have to report at least five items unless you have exclusions on all of the rest and including one of those items. The other thing to be aware of is that one of the menu items is going to disappear starting in 2014 as well for stage 1. So, if you used the providing the information patients on demand as one of the options, that one is no longer going to be a menu item. You need to find another. So let me know when I have the slides back again. In stage 1, the measures in stage 1, there are a couple of changes.

Pardon? You know, I could log in probably, could I share my desktop somehow or do something like that?

They're -- geri's working with a woman from Buccaneer right now, so beal see if we can get -- see if we can get through. We're going to mute so you don't have to hear us discussing this.

Okay. I can hear what you're saying.

I guess the question is if you're out, keep going. Again, I apologize. One of the changes is that instead of unique patience for medications, you can continue measuring that way. Paul?

Yes.

If -- try hitting the arrow button opposed to the page down button to advance.

Ah.
There we go.

Thank you.

We're going to -- .

technology.

I don't know, was that a training issue or a -- no. [ Laughter ]

Anyway, we always know that quality improvement is a complicated thing and we just improved our process a little bit. Thanks, Paul, for bearing with that.

Well, thank you. Sorry for just using the arrows. This is a change in technology as I mentioned for the HEH R WEAPONS WEAPONS -- EHR. We talked about the different levels for the EHR, the bates, the core, and the menu, and this particular one talks about the elements that are in the EHR basically, they contain demographic CPOE, CDS, quality reporting and information exchange. The good news about this is that that means that this could form a foundation for all electronic records, be they at hospitals, clinics, or even other providers of healthcare as well. So the changes to meaningful use, as I mentioned, just a menu objectives. The exclusion part, I mentioned. That otherwise, there are no other changes. And stage 1 meaningful use, I mentioned already, the denominator can go from all patient or from each unique patient for the medication orders to the percentage of medication orders. Oops. Bad habits. For vital signs, your age limits have changed which, is a benefit and so now, over age 3 for blood pressure. Anyone for height and weight and can you separate the two so they're not tied to one or the -- don't have to do them both if you're interested in one or the other. You no longer have to test for the transition of key information because exchange is going to be much more important in stage 2 and there will be other elements similar to that, within the future stage 1s. This starts as of 2013 for both, in the 2013 payment year. The current objective of providing patients with electronic copy of the health and request to provide electronic access to health information and the second one is the menu item in the ambulatory world has been switched to a new stage 1 objective that is now core for 2014. And that is to provide patients with the ability to view online download and transmit their health information. Essentially, meaning they will have a Portal and what mean people known as a blue button, where they can retrieve their information and gather and keep it for themselves. This is going to correspond with the 2014 certification standards of the electronic health records. You will see something similar to this in stage 2 where actually people are going to be required to actually access this information. One of the things that a number of us know, another minor change is that immunizations are portable in terms of surveillance are now required and almost prohibited by law. It's still the same thing. You attempt to do it and, if you're not successful in stage 1, that is okay. You can still report that you attempted and you would still achieve meaningful use N. stage 2, it's required that you do ongoing and be successful. So, again, I apologize for that confusion. Any questions on the changes to stage 1? Let's open the lines.

All lines are unmuted.

Hearing none, I will move on. For stage 2, most of the menu items have become core. The percentages have increased for the ones that have been core, turnaround time for some elements is shorter. There is more health information exchange involved and more patients involvement as well. There are also some core measures that have been incorporated into other activities, so, for example, the stage 1 to stage 2 meaningful use, you have the same number of total objectives in
stage 1 to stage 2 with a few more cores that can you see. And the same is true for the hospitals.
Same number, just a few more core. So here in gray with the line through it are the stage 1 and in italics and bold are the new ones for stage 2. So CPOE has gone to 60% of all medication orders and greater than 30% of all laboratory and all radiology orders. Demographics, vital signs and smoking statives been increased to 80% -- status have been increased to 80% for both hospitals and clinics. We have five interventions that we're supposed to do coupled together with drug, drug, and drug-allergy. Finally, the review security risk analysis which we have done before and you need to do it once each year. No longer menu items is the incorporate lab results. That was so simple, they decided to increase the percentage on that, anyway, even though it was moved from menu to core. Generating a patient list by specific condition is now core. The new core objectives for stage 2 for everyone is to provide a summary of care document for greater than 50%. That is old. What is now is 10% need to be sent electronically and at least one of those needs to be sent to another organization with a different vendor's EHR. So, for those of you who do not have a hostile that -- hospital that can accept that type of information, I'm not sure if it's CMS or OCMP, one of the organizations will be sending -- setting up a system for you to send the information to them and can you test that the system can not truly do it successfully and be able to achieve this, even though no one in the referral network is capable of receiving an electronic transfer of care or referral. Finally provide online access to health information. For half of the people with 5% actually accessing it. The first half is the new one for stage 1, but now we actually have people actually accessing it. We'll talk about ways to accomplish that later. For professionals, their summary of care within the business day. E-prescribing is up to 65% from 40%. Use the, HR to identify and provide reminders to patient followup. That was formally menu in the last core. And a new one is more than 5% of patients and to send a secure message to their eligible professional. The hospitals, we'll just mention these. They need to go successful on going lab results and electronic surveillance and they're going need to do something like bar code inside administrations to make sure the right med is getting to the right person. And the ones that we mentioned before, you know, when we first saw the rule, we were surprised that problems to medication lists and medication allergy lists didn't appear as one of the core criteria and that is included into the transition of care slash referral summary. And if they don't appear within the referral summary, oh, not be able to be counted as a transition of care referral summaries. If all of those three elements are required. I will say that it's a bit confusing, though. When I look at the elements of transfer care referral document, the documents that comes from CMS actually states that these are all required. Now they said the same thing in stage 1 where they had the whole litany of things that you need to include and finally, they backed off and said basically, you have to include labs, meds, and problems. So, I am not sure if they're going to make all the mandatory elements and there is nothing in there. You will not do it. I don't think that that is the case, but I was really confused by the language in that document that they released later O. so, I will need clarification on that. In this column, you will see the usual suspects. They want to have in your referral of transfer of care and the new limits -- elements ironically, the count diagnosis done before. And we're also going to have the patient's functional status which, is a good one. And also, care plan field, which can be blank if there isn't one and they want that to be included with care goals and finally, a care team to know who is involved in taking care of the patients. So for the menu objectives, these three are men eye objectives, again, for both hospitals and providers.
and these are mandatory or -- those are three of the ones that are, the first three menu items. More than 10% of images results are accessible through certified ehr technology. The result and image are correctly accessible through the technology or there is a link in the EHR which links to a place where you can see the imaging results and the report. Electronic notes and patient records for 30% of unique patients. And family health shift recorded in 20% of unique patients as well. So, for EPs, other menu items are successful ongoing transmissions of surveillance. And two other ones which have to do with registries, one is cancer patient information registry and another is a specialized registry. There are also three here that are listed for the hospitals as well for your information. So issue light pause for a moment and see if there are any questions on the stage 2 requirements.

Dr. Kleeberg.

Yeah.

I was on the understanding if you go back a slide, we had to select one of number 4, 5, or 6. Not any three of 6, you had to do one of 4, 5, and 6 and then you pick two of the other three. Is that incorrect?

I have not heard that. Where did you hear that from?

I thought that is what I thought -- I have to check.

We'll check on that but that would be completely new to me. I don't remember seeing that any place.

Okay.

Dr. Kleeberg what, do they mean by number two, record electronic notes. What do they mean?

They're talking about in a sense of progress notes or visit notes that needs to be in the patient's electronic health record. It can be either something where they fill out a form online and put, you know, auto populated with click boxes. It can be something they type in. It can be something that dictated and put in later and it could be a document that is scanned in as long as there is optical character recognition of the scanned document and it actually contains text.

Okay. Great. Thank you.

The whole idea is to make it text-word searchable. Other questions?

What is the definition of a unique patient? Of unique patients?

I was thinking of a smart answer. Many of us have our unique patients, no, but unique patients is essentially, you know, let's say you have one patient coming in once during the measurement period and someone else that comes in five times during a measurement period. You would have two unique patients. So they're not measuring every time you see that patient for the multiple visits, but you're making sure that there is a note in that patient's chart, at least a note in the patient's chart regardless of the number of visits. That is not true for the after visit summary or the clinical summary. Those need to be 50% of the face-to-face encounters where the clinical summary is produced. That is the example of the difference.
Okay. Let's go on to the next one here. Changes to the quality reporting. Providers are allowed to choose 6 out of 44. Now they're going to choose nine out of 64 and those nine need to come from at least three of the six national quality strategy domains. I'm not sure if you recall, but during the propose rule, they were saying, well, should we mandate eight of them and allow you to opt in one of them or should we allow you to optimally do all of them? Their concern about the latter was that if they allow people to opt anyone that they wish, they would not get enough data on any one particular element and they were concerned if they used the former, that there would be a lot of providers who would be reporting zeros. So, actually, this turns out to be a good compromise, and I will show you what they, what that compromise is in a moment. Essentially, you need to choose 9 core measures. And they need to come from at least three of the quality dohighway patrols. Hospitals have something similar. They have to do 16 out of 29. For 2013, you will report the quality measures the same way you did before. Can you. You just attest online. But there are some optional methods available for hospitals and providers. So providers you can use the procurous e reporting pilot and hospitals can use a reporting pilot as well. If you're doing, if you're a provider and doing Medicaid, you would submit them to the state the way the state requires it. In 2013, it's -- 2014, it's going to change. It's going to be electronic for all eligible Medicare providers, that is in the second year of meaningful use. The Medicare error providers again, it will be depending on what the state requires. So, quality measures, no change in specifications for 2013. There are some in 2013 that have been deleted and three deleted are listed here. They have 23 new ones giving you a total of 64. Hospitals with the stat at 14 new and kept the old 15. So, as know, the patients with diabetes can be defined multiple ways, depending on what you're measuring. There are did any different ways to measure your population when you're doing these. Again, the CMS and ONC have the goal to make them be consistent across the different measures so that problem will begin to resolve as time goes on and starting in 2013. So, we should so an improvement of that coming. So, here are the six national quality strategy domains from which you need to select a quality measure that fulfills each of these. And there is some help with that, as I mentioned, for the eligible professionals. That is on our next slide. In the file rule, they did propose these four for people who so adults. Those are not required, but these are recommended ones. So if you see adults, it's recommended that you choose these nine elements and, actually, they come from all six of those domains. So, you really have it covered as an adult provider. For those who take care of children, they recommend these, and they also come from the three domains as well. So, again, this is an option for professionals to consider. I don't have a slide that really shows or breaks down all 64 of the measures like we did the 44 or so of the ones that are currently active. I do suggest that we can at some point take a look at some of those measures, but I do suggest, and we'll talk about this at the end. It will be a good idea for to you think about right now which ones you would want to measure on. Again, the decision support criteria that you select needs to be oriented towards one of the quality measures upon which you're going to report. So, I did -- oops. That is interesting. The two columns are on top of each other. There is EDthroughput and schemic stroke, the ones we have seen before. VTE and schemic hemorrhagic stroke and new measures, the heart attack measure and pediatric measure. I think that one maybe -- I know there is a pneumonia one, a surgical one and a care coordination one. I can't really read them. We'll have to assume that they there. So this talks about how will be reporting some of your quality measures in 2014, and it's pretty small on my screen. I am hoping you will be able to read this. I don't know. The first one, for the first row, those are for EPs that are in -- are in their first year of demonstrating meaningful use. The way you have done it before, it's aggregate, all patients from all plans, and you basically do it via the station and so your 9 quality measures you would attest
to your numerators and denominators. If you're beyond the first year of demonstrating meaningful use, can you -- your option one is to do the same thing except to electronically report those as opposed to attesting to those. Or your other option is through the PQRS program and is on a per-patient basis under Medicare. For the group performing option against for those demonstrating the first year of meaningful use, can you do the Medicare shared savings program or pioneer ACO version where you do it per patient under Medicare. Or you can also use the PQRS group reporting method where it's per-patient under Medicare as well. More on that to come as we get closer to 2014. So, there is no change in the quality reporting period except for 2014 as I mentioned before and since the both your quality measures and your attestations of meaningful use in 2014 needs to cover a calendar year quarter or fiscal year quarter, so as can you see, this is what we had the question on before, so for 2014, 2014 alone for those at -- who are at any stage other than their first year of meaningful use, they would need to report during a quarter period, but they, the date on which they attest really doesn't change. So you still have 60 days until the end of the measurement period to be able to file your attestation so for professionals, that would be the February 29th or March 1st. And for hospitals, that would be I think it's November 30th. All right, so after that, it's the full-year in the standard program. Any questions about the details on what we have talked about right now? Let's open it up. Can we open the lines, please.

All lines are unmuted.

Okay. Well, let's start. Now starts to open the discussion part of. This as you can see, there are a number of different changes coming in stage 1 and in stage 2 and they going to impact you and what you do. I thought we would start out with talking a little bit about some of those things. So, I think you may have received some of these in the flower about the program starting. I will go through one of these and can you -- we can begin to talk about how can you do this. One of the things you're going to do is you're going to wind up sharing more information with patients. You're going to be using a patient Portal, the patients have the ability to see their problem list, their medication list, the allergy lists, the lab results. Also the potential is to, you know, since secure messaging is a part of it to message the providers. I would like to hear from the group what you think are some of your concerns around that and how you might be able to mitigate some of those concerns.

Can you make sure the phone lines are open?

All lines are open. There doesn't appear to be any questions.

I think everyone's being a little shy.

Or overwhelmed.

Yes. [ Laughter ]

All right. Then start with a simple question. Or a -- and can you please repeat that.

Paul, this is Phil Daring, and I believe -- mailers is on the line. I know that Tom had some concerns about the deployment of the Portal and how that might take place and some of the challenges. Am I right about that, Tom?

I'm trying to understand what you asked me, Phil.
Are you -- I thought that you were concerned about the ability to deploy the Portal in time to meet those requirements for the percentage of patients that you are going need to communicate with.

No, I think the question I asked was do we interpret the language to -- so we use epicure, and we have my chart, and the question is do people have to actually have active mychart accounts or do we just give them the activation codes and is that enough to count them?

Well, the question is to count them for what?

Well, for the download capabilities, the online -- .

No. They have to download it.

The 5% have to -- I think the question that put out there was epic is saying if you deploy, if you give people the codes and they don't activate, you have given them the capability.

That has to do with -- [ Indiscernible ]

That has to do with the after-visit summary. So you can tell a person your after visit summary, your summary is online, and I would be happy to prints you a -- print you a copy if you want a printed copy. They can ask for one. If you told them it's online, whether or not they accept it, is it available to them. It's just them getting their I.D. and being able to access it and that would count if they have the, if you have the Portal up and you put it there.

Yeah, but for the 50% need, the capability to be online is giving them the activation codes enough for that.

For the 50% who have gotten the after visit summary -- .

It's not I'm not talking about the after visit summary. I'm talking about the online download capability one.

That is 5%.

Yes.

And they actually have to go online and download it.

Yup, and I'm saying there is to 2 measures for that objective. One is 50% need to have access and 5% need to do it. So, to meet the 50% threshold, it's just giving them the access code, is that enough?

Correct. Yes.

Okay. That is what I think the question was.

I'm sorry.
Yup. Thank you.

So, again, I am interested in hearing from some of the folk its that don't have a Portal up because I think if you haven't had a Portal up, and you don't have -- you have people looking at -- you don't want people look at your record system, it's entirely possible providers have been using the electronic record methods for communicating to each other. Opening it up to patients creates a whole different issue because there might be information that providers have been putting them there that you may wish to clean up. For example, the person if they have the -- on the record system as a drug seeker or lingerer, someone that we sometimes annotate a problem list with and that is just notes to ourselves or colleagues.

I think that that is a real concern, and it's part of why there was a hesitation in our environment to push out information from the chart to the Portal. The physician's do use the secure messaging to communicate with patients sending lab results and doing secure messaging back and forth. There was resistance to pushing out things like problem lists and there was resistance for that same reason about the after-visit summary, and they chose to go with the assessed problems for the visit because of. That.

Is this Linda?

Yeah, it is. You know, I think that is going to be a real -- it's interesting. I think that that philosophically is where the world is going and from a cultural standpoint recognizing that in the future patients will have full access to their chart electronically and we'll see what we put in our progress notes and I think that that will be hard for some physicians to adjust to. It's also going to be a very interesting world about it comes to what we have to put in our notes to support our level of reimbursement. So, I think there is lots of changes coming.

Linda Walling is helping. I will be interested in hearing from some of the folks who have actually flipped the switch and done that and what is your experience been. Has it been, have the positions -- physicians been flooded with e-mails and has there been problems or what has occurred as a result of the change? Anyone care to say it?

This is Cheryl from Partners OBGYN. We don't have a patient Portal at the present time, so our physicians don't communicate with the patients electronically. I think their number one concern is where in the day am I going to fit that in. I am already spending longer hours at the office and I'm already giving up lunchtime and now the patients are going to e-mail me and when am I going to do that? That is a good question.

So, I'm mostly experienced with those who have done this, it actually [ Indiscernible ] As long as you triage the e-mails in the same way that you triage phone calls. The other advantage is that the patient is doing the data entry opposed to your receptionist or your nurse doing the data entry, and because it's asynchronous, you're not playing phone tag. So, someone chime in if they disagree with me who has done this, but the places who have done this it works quite well and have not found patients to abuse the system. I just heard her talk -- this week saying that the patient sends three messages a year.

I think we have been spoiled a little bit by our triage nurses because when the question goes to the physician, they asked the patient, quote, non-quote, the right questions, so I understand that now we're going get the information from the patient, which can be good or bad. I think in our instance, sometimes the patient won't give us the questions, the answers to the questions that we
need, and so they'll be more -- there will be more bail maile going back and forth. They'll tell us the problem but oops, they forgot to mention, a, b, and c, which rot now when the physician deals with the problem, the nurse has gotten with that information, so the physician can answer the question the first time around.

So why would the physician now or not the nurse triage like -- like phone calls?

Well, sometimes the questions need to go to the physician because the nurse triage is doing just that. She's triaging it but show can't always answer the questions, but show at least has enough data to give to the physician and then the physician is capable of answering it the first time around.

Right. I maintain that e-mail message would be the same. It's going go to the nurse triage who is not clear k ask for more information. Interestingly, too, the chart is immediately available when the message comes in because the party is coming in with their chart. And then the nurse can annotate the message and forward it to the physician. And the physician can reply to the nurse and the nurse can reply to the patient. I mean there are any number of different ways that the process can be done to mirror or even facilitate what has been done in the telephone world.

Okay. Thank you. I totally missed that that the message can be answered by triage and not by the physicians.

Sure. It's just like phones. Just like the phone. They -- I told the nurse what to tell the patients or call them with their lab results, stuff like that. It's no different and it's more convenient.

And that, so when they say that the -- I think there was a percentage of how many messages in the first year are in the --

5% of patients. 5% of patients need to send a secure message to their clinic.

Okay. I missed the cling. I was thinking physician, which meant that physicians --

I'm sorry. You're correct. To the physician, to the provider, the eligible provider. You're correct.

So then when the response comes back from the nurse, that is okay? That qualifyd?

-- qualifies?

That is a good question. I would say yes. They're working with their provider. I don't think they - - I would say that is a good question that needs to be clarified. That's a good one.

I agree with you common sensewise, I may have a bad attitude go about the government because I don't think that qualifies.

Okay. So some of the things you may want to think about is completing the patients' problem, medication and allergy list. They're going to be seeing it and look at it online and it would be, you know, they're talking about this since page 3 where patients will be able to potentially correct those things orsen messages in a way to correct them. What you may wish to do, too, is set up a process for when patients see that there are errors. There is a way to notify you that there is an error. Ideally, you want them, do you want their medical information to be accurate? So,
you know, just like we can online with our shopping experiences and all of those things, the error we can notify them and they can be corrected, sometimes easily, sometimes not and you would want them to do the same thing with our health information. The other thing, the information, what kind of information do you want to share with patients? We talked about that and to pay some attention to what is in there. The last thing, since they're going need to become involved, you may want to encourage patients to get, really get more involved in their care. Was on the eye on at a presenting a, not this week but the week before, where one uses the summary to include information about how to log into the Portal, so it gives patients the Portal access any time they get an after visit summary if they're not already on the Portal and that gives them information about what sort of -- what they can do with the Portal and what they can't do with the Portal. And so, they have found a way to really increase patient involvement in using, in utilizing and becoming a part of the Portal opposed to turning it on and saying can you find that if you wish. They're pitch more active in doing that. The process will make it more likely that you will get that patient involvement to look at their record systems and to message you. The other thought on preparing your patients to become more involved.Okay. You may, you know, and this is something that was mentioned and needs to be clarified, too. For those every single small practice, does it night to have its own Portal? If you're an independent dermatologist and orthopedist, et cetera, et cetera, do you have to have your patients log in to each of your Portals or can you upload it to a health information exchange and it's available. That is yet to be determined. They not sure of the an sore that one. They have ideas and that answer is going to come out in an FAQ. The other thing to think about is exchanging information with others. For epic systems, which we have a few in our community, you will be able to not only send to other epic systems, but at least one needs to go to a different EHR vendor that you're not, with whom you don't have an ownership stake, spike and -- so to speak, you don't own them even though they have a different EHR. I will open these up to talk B. you will see all of these in advance and so if there any is any discussion or question on any of these. I would like to hear more from some of the questions from the group. Can you put them in the chat as well. Actually, one of the questions that came in the chat, will these slides be available after the presentation. It's hard to keep up with him and read them all. I'm sorry. Yeah, the slides will be available and I think we'll be sending it out to everyone once this is complete. At least that is what we have done in the past. So, again, I think it's going to be important to work with your vendor between they going to be delivering the product, to help them identify which ones that -- the quality measures, which are important to you so that they develop those quality measures. It's going to be hard for them to do all 64, like they did in for stage 1, and again, as I said earlier, since the physician support rules are interventions, they need to be tied to one of your quality measures. You will need to think about that as well. That is a particular challenge for larger systems who have lots of different specialties. The quality measures that a specialty may report will be different than primary care and they may need to build a number of different interventions for the support.

Paul.

Yes?

This is Phil.

I have a question about the certification criteria. The measurements for some of the requirements seem even more complex than in stage 1. Do you know if the certification criteria is going to require accurate dashboard reporting or ifle that still be left to the individual to determine who they're meeting the requirements?
It's required to be able to produce the outcome of the numerators and denominators.

--- denominators.

Right.

And does not mean they won't produce the dashboard.

Uh-huh.

As I recall, it's testing for accuracy. So they will have test data to demonstrate the accuracy of the collection of the report. But it's still, the devil is in the details. We thought we had it right for stage 1 and we found out there were many different problems than loopholes. I know they have tried to close all of those potential problems with stage 2, but I am sure we although encounter some. Vendors are not required to use a dashboard where you get to see, you know, graphically how you're doing with diabetes and with all of those things. They required to produce the numbers that can be then sent to CMS.

Great. Thank you.

Any other thoughts, Phil, or particular challenges that you see here for folks that they need to begin to think about?

Yeah, go ahead.

Paul, this is Geri. We have a question in our chat about how will, from Rhonda, how will they measure the patient use of the electronic access?

That is part of the standards criteria for the EHRs and that will be included in a log foil. When a patient does access, download or do that, it will be recorded within the system. So, again, there will be a outcome from the HEH R like with -- to tell you how many medications were ordered per patient, et cetera. It's a functionality into the EHR.

This is Linda, Paul. Along those same lines, I know that some of the groups that had been audited have really struggled with proving some of the yes-no attestations.

Yes.

Is that going to be addressed in -- it looks like almost all of the measures in stage 2 have numerators-denominators associated with them, so I'm assuming the association -- certification process will require the EHR to produce the numerators and denominators.

That's correct. States require for drug-drug/allergy reaction, to determine who did it and what level it was set at. That is part of the cert education criteria for stage 2 for drug-drug and drug-allergy. I didn't see a satisfaction criteria like that for clinical decision support, though in the -- and I haven't read that deeply because this problem rose recently around the decision support. There was the requirement in the functional measures to say that not only do you have to have a rule, you have to have the ability to measure the response. So whether the provider accepted it or overwrote it? I didn't see -- I don't know if there was a standard certification criteria for that. I actually wrote an e-mail into -- to ask them if there was. Some of our clients are getting this,
yeah, well, you took one screen shot in the beginning. How do you know if it's on the whole time and we were told that would be fine in the beginning. Now, the companies that are doing the audit say no, you need to show it's been on the whole time. What I have yet to have time to look at to see if certification criteria for stage 1 and certification criteria for stage 2 have requirements that there is a log of, the provider responses to a decision support and prevention. That is great if it's an alert. But that is not great if it's necessarily a flow sheet or an order set or something along that line. I don't know if we're measuring, if it's been triggered. I'm not sure if we're measuring if a flow sheet has been triggered. Again, those are all potential interventions and conceive English if there is a log -- conceivably, if there is a log file that following what is triggered, we're good to go. But dif a -- if a defender goes into the log foil and digs up the report, we have a defense. That is all I know about that, Linda's.

-- Linda.

Okay, thanks.

So, getting to the end of our hour, I don't want to run over. I think the important thing here from our learning and action network perspective is the fact that the quality measures are going closely begin to track into what we wish to do and our decision support interventions that we need to create, need to attach to the quality measures. And that is what our learning and action network is all about. Take the CHR, leverage it as a tool so that we're improving the quality of the care that we provide our patients. So, we'll be talking more about how we do that and ways to go about doing that and potentially ways to think about how you might creatively use the decisions support interventions to be able to achieve the quality levels that you wish with your measures over time as we go forward. I apologize for something like that, a sandpaper voice, but I had a bit of a cold and I'm getting over W. that, I will end and hand it back to Geri.

Thank you so much, Paul. I just wanted to remind everybody if do you have any other questions you that think of after the fact, can you certainly send them in to myself, Jeri or to cony geyer and her e-mail is cgeyer at ndqio.sdps.org. The next webinar is on February 20th, Wednesday from 1291 to 1:00 p.m. to on clinical decision support. Thank you, everyone, per participating today and have a great afternoon.

Operator: You may now disconnect your line. [Event concluded]