Navigating Promoting Interoperability Objective 5

Health Information Exchange (HIE)

Agenda

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- Re-branding the EHR Incentive Program
- Objective 5 specifications
- Navigating objective 5
- Stage 3 Medicaid PI + MIPS PI
- Takeaways

Re-Branding the EHR Incentive Program: Promoting Interoperability

HELLO

my name is

PROMOTING INTEROPERABILITY

What’s in a Name?

“The Centers for Medicare & Medicaid Services (CMS) is dedicated to improving interoperability and patients’ access to health information. To better reflect this focus, we’ve renamed the EHR Incentive Programs to the Promoting Interoperability (PI) Programs.”

CMS also renamed the Advancing Care Information category of Medicare MIPS to Promoting Interoperability.

CMS Interoperability Roadmap

The goals are:

- **2015-2017:** Send, receive, find and use priority data domains to improve health care quality and outcomes.
- **2018-2020:** Expand data sources and users in the interoperable health IT ecosystem to improve health and lower costs.
- **2021-2024:** Achieve nationwide interoperability to enable a learning health system, with the person at the center of a system that can continuously improve care, public health, and science through real-time data access.

Interoperability Standards

Standard	Description
VOCABULARY & CODE SETS (SEMANTICS)	The information is universally understood
FORMAT, CONTENT & STRUCTURE (SYNTAX)	Information is in the appropriate format
TRANSPORT	The information moves from point A to point B
SECURITY	The information is securely accessed and moved
SERVICES	Provides additional functionality so that information exchange can occur

Objective 5 Specifications

Health Information Exchange

Health Information Exchange	
Objective	The EP who transitions their patient to another setting of care or provider of care or refers their patient to another provider of care provides a summary care record for each transition of care or referral.
Measures	The EP that transitions or refers their patient to another setting of care or provider of care must—(1) use CEHRT to create a summary of care record; and (2) electronically transmit such summary to a receiving provider for more than 10 percent of transitions of care and referrals.
Exclusion	Any EP who transfers a patient to another setting or refers a patient to another provider less than 100 times during the EHR reporting period.

* For the purpose of this objective, “HIE” is an action. “HIE” can also refer to infrastructure that supports the exchange.

Attestation Requirements

- DENOMINATOR: Number of transitions of care and referrals during the EHR reporting period for which the EP was the transferring or referring provider.
- NUMERATOR: The number of transitions of care and referrals in the denominator where a summary of care record was created using CEHRT and exchanged electronically.
- THRESHOLD: The percentage must be more than 10 percent in order for an EP to meet this measure.
- EXCLUSION: Any EP who transfers a patient to another setting or refers a patient to another provider less than 100 times during the EHR reporting period.

Transition of Care – The movement of a patient from one setting of care (hospital, ambulatory primary care practice, ambulatory, specialty care practice, long-term care, home health, rehabilitation facility) to another. At a minimum this includes all transitions of care and referrals that are ordered by the EP.

Summary of Care Record (SoC)

Problem list	Medication list	Allergy list	Patient name
Patient demographics	Referring provider contact info	Procedures	Encounter diagnoses
Labs	Immunizations	Vital signs	Smoking status
Functional status	Care plan	Care team	Reason for referral

Additional Information

- Must include problem list, medication list, allergy list or document that there are no active problems/meds/allergies
- Care plan must include problem, goals and instructions
- Lab results may be limited by clinical relevance
- Referring provider must have reasonable certainty of receipt
- Exchange must comply with HIPAA
- Transitions of care/referrals occurring between providers sharing access to CEHRT may be either excluded or included unilaterally

Navigating Objective 5

Define Transition of Care (ToC) Network

- Establish ToC Encounters
    - New patients
    - Primary > Specialty
    - Specialty > Primary
    - Hospital admission
    - LTC, home health, rehab

- Engage with ToC partners
    - Start with partners known to be using same CEHRT
    - Contact practice manager/care coordinator/provider to inform of interest in sending patient information via CEHRT
    - Ask if practice has Direct messaging address
    - Document results to create/maintain partner directory in CEHRT
    - eFax may be functional in CEHRT but <u>does not count</u>

Partner with CEHRT Vendor

- How to document ToC?
  - Epic: Care Everywhere
  - eCW: “P2P” messaging
  - Practice Fusion: “Add referral”

- How to create SoC?
  - Create file outside of ToC workflow
  - Automatically created during ToC workflow
  - Attach additional files

- How to send SoC?
  - Send via Direct messaging
  - Publish to HIE
  - Exchange via secure file sharing outside CEHRT

Build Culture of HIE

- Internal ToC
  - Document each ToC between providers within organization
  - Create and send SoC using Direct messaging
  - Easy introduction and counts towards 10%

- ToC to partner using same CEHRT
  - May have ability to search for Direct address by name
  - Share tips based on common interface and experience

- ToC to partner using different CEHRT
  - More difficult to identify Direct address
  - May be fees associated if partner CEHRT uses different health information service provider (HISP)

- Automate publishing to HIE

Stage 3 Medicaid PI + MIPS PI

Stage 3 Medicaid PI: Objective 7

Health Information Exchange (HIE)	
Objective	The eligible professional (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 electronic health record (EHR) using the functions of certified EHR technology (CEHRT).

Objective **requires 2015 Edition CEHRT**, which enables managing referral loops by both sending and receiving updated SoC at each ToC.

RETAINS EXCLUSION for <100 inbound or outbound ToC

Stage 3 Objective 7: Measure 1

Providers must attest to all three measures and must meet the threshold for at least two measures to meet the objective.

Measure 1 – For more than 50 percent of transitions of care and referrals, the EP that transitions or refers their patient to another setting of care or provider of care:
(1) Creates a summary of care record using CEHRT; and
(2) Electronically exchanges the summary of care record

Carries forward Stage 2 PI Objective 5 but increases threshold to exchange of SoC for over 50% of outbound ToC.

Stage 3 Objective 7: Measure 2

Measure 2 – For more than 40 percent of transitions or referrals received and patient encounters in which the provider has never before encountered the patient, the EP incorporates into the patient's EHR an electronic summary of care document.

Mirrors Stage 2 Objective 5 but requires receiving SoC at over 40% of inbound ToC. Encourages both parties to continuously exchange SoC to coordinate care for mutual patient.

Stage 3 Objective 7: Measure 3

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 performs a clinical information reconciliation. The provider must implement clinical information reconciliation for the following three clinical information sets:
(1) Medication. Review of the patient's medication, including the name, dosage, frequency, and route of each medication.
(2) Medication allergy. Review of the patient's known medication allergies.
(3) Current Problem list. Review of the patient's current and active diagnoses.

New concept that allows for extracting "structured data" from incoming SoC directly into patient chart to update clinical information.

Proposed 2019 MIPS PI Objective

Health Information Exchange	
Support Electronic Referral Loops by Sending Health Information	20 points
Support Electronic Referral Loops by Receiving and Incorporating Health Information	20 points

Differs slightly from Stage 3 Objective 7:

- Not required; scoring system means more points for more exchange
- Merges Stage 3 measures 2 and 3 into one, requiring clinical information reconciliation only if receiving inbound SoC
- Allows use of other document types that may include more or less clinical elements for different purposes

Takeaways

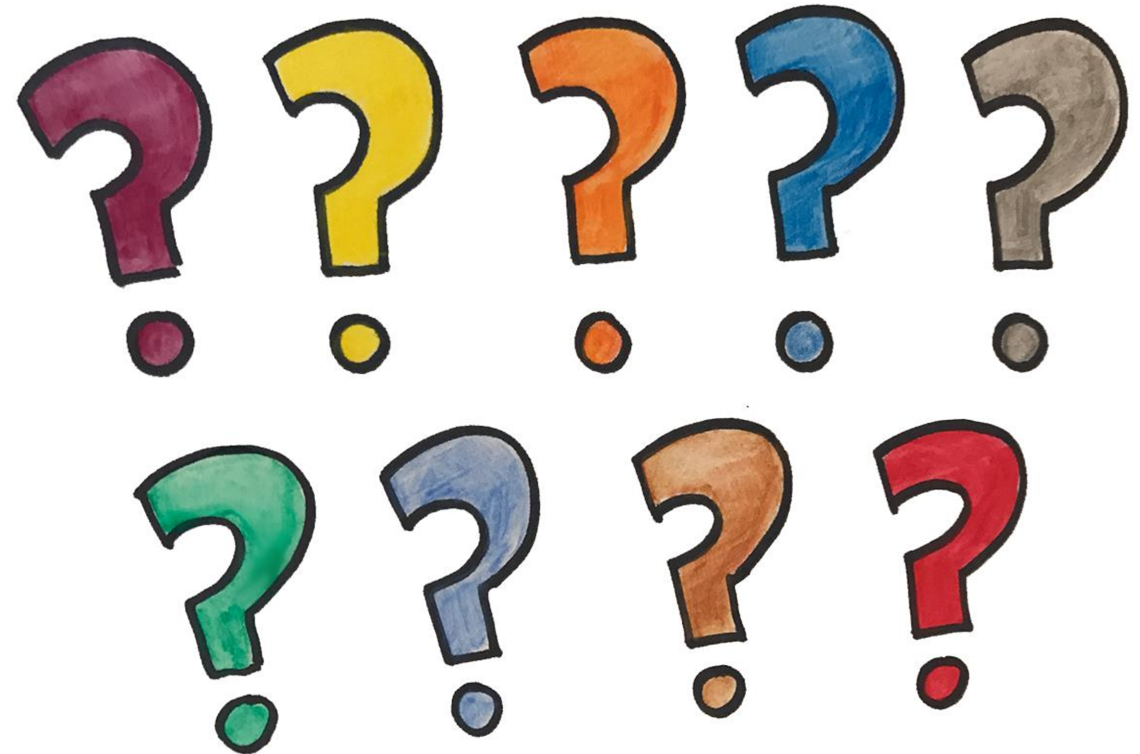
Interoperability is High Priority

- Name change reflects CMS commitment to electronic exchange
- Medicaid PI Stage 3 significantly increases HIE activities and thresholds
- Medicaid PI Stage 3 for hospitals and Medicare MIPS PI highlight HIE
- 21st Century Cures Act expressly prohibits “information blocking” practices “likely to interfere with, prevent, or materially discourage access, exchange, or use of electronic health information”
- PI Programs require attestation statement of not engaging in “information blocking”

Plan Transition to HIE Care Coordination

- Move away from fax gradually
- Set targets based on PI goals
- Train staff on new processes
- Test HIE with tentative partners
- Establish continuous HIE with willing partners
- HIE cannot replace existing workflows immediately:
  - Not all partners use CEHRT
  - Exchange of information not available electronically (not in SoC)
  - Insurance plans may enforce non-CEHRT referral systems/forms

Q & A



Help Desk Information

For any Promoting Interoperability Program related questions, please use the contact information below:

- Support Line: 855-684-3571 (855-68-HELP-1)
- E-mail: muhelpdesk@chitrec.org