Overview of Meaningful Use Requirements

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Associate Chief Medical Information Officer
Cleveland Clinic

DISCLAIMER: The views and opinions expressed in this presentation are those of the author and do not necessarily represent official policy or position of HIMSS.
Conflict of Interest Disclosure

Robert White, MD, FAAFP
Has no real or apparent conflicts of interest to report.
Session Learning Objectives

• Review the CMS Meaningful Use EHR Incentive Program, including criteria, purpose, timeline and updates
• Discuss how to overcome challenges eligible providers and staff may face in achieving Meaningful Use
EHR Meaningful Use Defined

- Meaningful use is using certified electronic health record (EHR) technology to:
  - Improve quality, safety, efficiency, and reduce health disparities
  - Engage patients and family
  - Improve care coordination
  - Improve population and public health
  - Maintain privacy and security of patient health information
Stages of Meaningful Use

**Stage 1**
Data Capture and Sharing
- Capturing health information in a standardized format
- Track key clinical conditions
- Communication of information for care coordination processes
- Report Clinical Quality Measures & public health information
- Patient and family engagement

**Stage 2**
Advanced Clinical Processes
- More rigorous health information exchange (HIE)
- Improved Patient Care through clinical decision support, care coordination and patient engagement
- Electronic transmission of patient care summaries
- More patient-controlled data

**Stage 3**
Improved Outcomes
- Improving quality, safety, and efficiency
- Decision support for national high-priority conditions
- Patient access to self-management tools
- Access to comprehensive patient data through patient-centered HIE
- Improving population health

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PHYSICIAN REGIONAL EVENT DINNER SERIES
## Eligible Professional Progress
### Data through 3/31/14

<table>
<thead>
<tr>
<th>Year</th>
<th>Unique EP Paid</th>
<th>Unique EPs Registered</th>
</tr>
</thead>
<tbody>
<tr>
<td>2014</td>
<td>61 Stage 1 – 11 Stage 2 – 50</td>
<td>29,592</td>
</tr>
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</table>

Total US Professionals – 537,600 (HIT Policy Committee data)
Registered Professionals – 465,887 (86.7% of total professionals)
Program to date paid - $8,595,884,046 (includes MAO)

Data at: [CMS data](#)
## Eligible Professional Progress
### Data through 9/31/14

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Total US Professionals – 537,600 (HIT Policy Committee data)  
Registered Professionals – 496,521 (92.4% of total professionals)  
Program to date paid - $10,191,234,555 (includes MAO)

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Data through 9/31/14

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                   Stage 2 – 2,282 | 60,226 |
| 2014 | Stage 2 – 11,478 (11/1/14) |  |
| 2014 | Stage 2 – 16,455 (12/1/14) |  |
| 2014 | Stage 2 – 16,359 (1/1/15) |  |

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# Eligible Professional Progress Data Comparison

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<thead>
<tr>
<th>Year</th>
<th>Unique EPs Paid (All Stages)</th>
<th>Unique EP Registered (Program to Date; 11/14)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2012</td>
<td>257,109</td>
<td></td>
</tr>
<tr>
<td>2013</td>
<td>307,115</td>
<td></td>
</tr>
<tr>
<td>2014</td>
<td>76,730 (Stage 2 – 16,359)</td>
<td>504,531</td>
</tr>
<tr>
<td></td>
<td>6.4% of 2012 EPs</td>
<td></td>
</tr>
<tr>
<td></td>
<td>25% of prior year EPs</td>
<td></td>
</tr>
</tbody>
</table>

Data at: [CMS data](#)
Medicare EHR Incentive Program Basics

• Program began in 2011

• The last year to begin participation is 2014
  – To receive the maximum payment, EPs must have started by 2012
    • Maximum incentive payment is $43,720
    • Subject to 2% sequestration

• Who is eligible?
  – Doctors of medicine or osteopathy
  – Doctors of dental surgery or dental medicine
  – Doctors of podiatry
  – Doctors of optometry
  – Chiropractors
Medicaid EHR Incentive Program Basics

• Program began in 2012 and will end in 2021
  – The last year to begin participation is 2016
  – First year is typically Adopt, Implement or Upgrade (AIU)
  – EPs can skip multiple years and receive up to 6 payments by 2021
    • Maximum incentive payment is $63,750

• Who is eligible?
  – Doctors of medicine or osteopathy
  – Nurse practitioners
  – Certified nurse-midwives
  – Dentists
  – Physician Assistants in an FQHC or RHC that is PA-led
Core and Menu Set Objectives

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Stage 2 Meaningful Use At a Glance

Stage 2

17 Core Measures
3 of 6 Menu Measures

9 Total Clinical Quality Measures

29 Total Measures
# Stage 2 Core Objectives – Measure Increases

<table>
<thead>
<tr>
<th>EP Objective</th>
<th>Stage 1 Measure</th>
<th>Stage 2 Measure</th>
</tr>
</thead>
<tbody>
<tr>
<td>E-Prescribing</td>
<td>40%</td>
<td>50%</td>
</tr>
<tr>
<td>Record Demographics</td>
<td>50%</td>
<td>80%</td>
</tr>
<tr>
<td>CPOE*</td>
<td>30% (meds)</td>
<td>60% / 30% / 30%</td>
</tr>
<tr>
<td>Record Vitals</td>
<td>50%</td>
<td>80%</td>
</tr>
<tr>
<td>Record Smoking Status</td>
<td>50%</td>
<td>80%</td>
</tr>
<tr>
<td>Clinical Decision Rule(s)</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>Clinical Summaries</td>
<td>50% / 3 days</td>
<td>50% / 1 day</td>
</tr>
<tr>
<td>Secure Electronic Messages</td>
<td>N/A</td>
<td>5%</td>
</tr>
</tbody>
</table>

* CPOE = 60% medication, 30% laboratory, and 30% radiology orders

**New!**
## Stage 2 Core Objectives – Menu to Core

<table>
<thead>
<tr>
<th>EP Objective</th>
<th>Stage 1 Measure</th>
<th>Stage 2 Measure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Lists</td>
<td>Yes</td>
<td>Yes – Menu to Core</td>
</tr>
<tr>
<td>Patient-Specific Education Resources</td>
<td>10%</td>
<td>10% - Menu to Core</td>
</tr>
<tr>
<td>Medication Reconciliation</td>
<td>50%</td>
<td>50% - Menu to Core</td>
</tr>
<tr>
<td>Clinical Lab-Test Results</td>
<td>40%</td>
<td>55% - Menu to Core</td>
</tr>
<tr>
<td>Patient Reminders* / Preventive Care**</td>
<td>20%</td>
<td>10% - Menu to Core</td>
</tr>
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</table>

* Patient Reminders (Stage 1) – 20% off all patients 65+ or 1-5 yrs. sent reminder

** Preventive Care (Stage 2) – 10% of all patients with 2+ office visits within 24 months prior to EHR reporting period
Menu Set Objectives

- Stage 2 has a total of 6 Menu Set Objectives
  - EPs must report on 3 of 6
    - Of the 6, 5 are brand new objectives!
  - 3 are public health focused and 3 address capturing information as structured data

  - Electronic Notes – New!
    - 30% / Record electronic notes in patient records (created, edited and signed by EP)

  - Imaging Results – New!
    - 10% / Imaging results consisting of the image and any explanation or other accompanying information are accessible through CEHRT

  - Family Health History – New!
    - 20% / Record patient family health history as structured data; first-degree relatives
Menu Set – Public Health Objectives

• Syndromic Surveillance Data Submission – Updated!
  – Successful ongoing submission of electronic syndromic surveillance data from CEHRT to a public health agency for the entire EHR reporting period

• Report Cancer Cases – New for Stage 2!
  – Successful ongoing submission of cancer case information from CEHRT to a public health central cancer registry for the entire EHR reporting period

• Report Specific Cases – New for Stage 2!
  – Successful ongoing submission of specific case information from CEHRT to a specialized registry for the entire EHR reporting period
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An In-Depth Look at Complex Objectives
Four Areas of Focus in 2014

- **Transitions of Care**
  - Sharing structured summary of care records electronically for each transition of care or referral

- **Patient Engagement**
  - Sharing or communicating information with patient electronically

- **Public Health Reporting**
  - Reporting information to your Department of Public Health (or similar agency) as appropriate

- **Protect Electronic Health Information**
  - Protecting electronic health information through appropriate technical capabilities
Summary of Care / Transitions of Care

• Objective:
  – EP who transitions their patient to another setting of care or provider of care or refers their patient to another provider of care should provide a summary care record for each transition of care or referral

• 3 Measures:
  – Measures 1 & 2 must both be met
    • Measure 1: EP who transitions or refers patients provides a summary of care record for more than 50% of transitions of care and referrals
    • Measure 2: EP who transitions or refers patients provides a summary of care record for more than 10% of such transitions and referrals with
      – (a) Electronically transmitted using the CEHRT to a recipient, or
      – (b) Where the recipient receives the summary of care record via exchange facilitated by an organization that is a eHealthExchange participant or in a manner that is consistent with the governance mechanism ONC establishes for the eHealthExchange
Summary of Care / Transitions of Care

• Third Measure:
  – Measure 3 must have one of the following criteria met
    • Conducts one or more successful electronic exchanges of a summary of care document counted in “Measure 2”
      – The sending and receiving EHRs must be different
    • Conducts one or more successful test with the CMS designated test EHR during the EHR reporting period
      – CMS is setting up a “Test” site for this exchange so that the EP may meet the measure
Summary of Care / Transitions of Care

A standard Continuity of Care Document (CCD) is used by many EHRs. Items that need to be included in a summary of care record:

- Patient Name
- Referring or transitioning provider’s name & contact
- Procedures
- Encounter diagnosis
- Immunizations
- Laboratory test results
- Vital signs (height, weight, blood pressure, BMI)
- Smoking status
- Functional status
- Demographic information
- Care plan field, including goals and instructions
- Care team
- Reason for referral
- Current problem list
- Current medication list
- Current medication allergy list

- Fields for problem list, medication list, and medication allergy list must be completed or that the patient has none of these
- Minimum of 100 in a measurement period necessary
- This far, 89.5% of EPs excluded this measure in 2014 (CMS)
Patient Electronic Access / Engagement

• Objective:
  – Provide patients the ability to view online, download, or transmit their health information within 4 business days of the information being available to the EP
    • Transmission does not include electronic media (USB, CD, etc.)

• Measures:
  – Measure 1 = More than 50% of all unique patients are provided timely online access to their health information
  – Measure 2 = More than 5% of all unique patients view, download, or transmit their health information to a third party
  – Starting in 2014, Stage 1 EPs must meet Measure 1 also
Patient Electronic Access / Engagement

• CMS has listed these possible exclusions:
  – Any information that is prohibited by any federal, state or local law does not need to be included
  – Any information that the provider believes could cause substantial harm to the patient does not need to be included
  – If a specific data field is not available to the EP at the time the information is sent to the patient portal, it does not have to be made available and the EP can still meet the measure

• Once the information becomes available, the EP must make it available within four (4) business days

• This provides coordination with HIPAA Privacy regulations
Core – Immunization Registries Data Submission

• Objective:
  – Capability to submit electronic data to immunization registries or immunization information systems (IIS) except where prohibited, and in accordance with applicable law and practice

• Measure:
  – Successful ongoing submission of electronic immunization data from CEHRT to an immunization registry or Immunization Information System for the entire EHR reporting period

• Exclusions:
  – See your State Medicaid Program for details
Core – Protect Electronic Health Information

• HIPAA Compliance and Security Risk Analyses (SRA)
  – The requirement to conduct a HIPAA SRA was codified with the April 20, 2005 HIPAA SECURITY RULE EFFECTIVE DATE!!
  – Thus it has been a requirement since that time, including the need for periodic evaluations
  – Meaningful Use simply added another reason for completing a SRA-and the need to conduct or review for each MU payment year
Core – Protect Electronic Health Information

• 2014 Edition Stage 1 and Stage 2 Requirement
  – Eligible Professional CORE Measure “Protect Electronic Health Information”
    • Protect electronic health information created or maintained by the Certified EHR Technology through the implementation of appropriate technical capabilities
  – This is a yes/no attestation measure with no exclusions

• What does the HIPAA Security Rule say?
  – “Risk analysis (Required). Conduct an accurate and thorough assessment of the potential risks and vulnerabilities to the confidentiality, integrity, and availability of electronic protected health information held by the covered entity.”
Core – Protect Electronic Health Information

• HIPAA Security Risk Analysis – what does this mean?
  – It is **NOT** a checklist but specifically defined steps!
  – It entails a formal review of risks to ePHI and your information security:
    • ePHI inventory and network or system characterization
    • Review of controls or safeguards
    • Review of threats and vulnerabilities including prior incidents
    • Criticality analysis
    • Review policies and procedures
    • Review likelihood of threat exploitation
    • Risk analysis
Core – Protect Electronic Health Information

• EHR Specific Focus – what should I do?
  – Roles and permissions - security settings
  – Audit logs
  – Server location (even if you use a remote data center)
  – Contingency and disaster recovery
  – Periodic testing
  – Specific MU areas like providing an electronic copy, patient summaries, patient reminders, patient access (portals), exchange of data

• Why should I care?
  – Audit focus
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Clinical Quality Measures (CQMs)
Six National Quality Strategy Domains

**Patient Safety**
Make care safer by reducing harm in the delivery of care

**Patient & Family Engagement**
Ensure that each person and family are engaged as partners in their care

**Care Coordination**
Promote effective communication and coordination of care

**Population & Public Health**
Work with communities to promote wide use of best practices to enable healthy living

**Efficient Use of Health Care Resources**
Make quality care more affordable for individuals, families, employers and governments by developing and spreading new health care delivery models

**Clinical Processes / Effectiveness**
Improve quality, safety and efficiency; reduce health disparities
CMS Recommended CQMs for EPs

• CMS published a recommended core set of CQMs for adult and pediatric practices.
  – These were chosen by CMS based on several factors:
    • Conditions that
      – Contribute to the morbidity and mortality of Medicare and Medicaid beneficiaries
      – Represent national public health priorities
      – Are common health disparities
      – Disproportionately drive health care costs and could improve with better quality measurement
    • Measurements that
      – Would enable CMS, States and EPs to measure quality of care in new dimensions
      – Measures that include patient and/or caregiver engagement
Options for Submitting CQMs - 2014

• Option 1: **EHR Incentive Program** submissions only:
  - Attest to CQMs through the Medicare Registration & Attestation System.
    - Must attest for **one quarter** in CY 2014
    - EHR Incentive payments will be held until you submit CQMs
    - Electronic submissions for CY2014 will be accepted until Feb 28, 2015

  – Notes for EHR Incentive Program submission:
    - This does not enable you to align with submissions for the Physician Quality Reporting System (PQRS) program
Options for Submitting CQMs - 2014

• Option 2: Submission through the PQRS System

  – Submit and report PQRS CQMs under the PQRS EHR Reporting option using CEHRT.

  • A full year (Jan – Dec) must be submitted to receive credit for the EHR Incentive Program and the PQRS program.

  • You can submit either an individual’s or a group’s CQMs through the PQRS Portal/GPRO.

  • You must submit patient level CQM data using 2014 CEHRT with the latest CQM specification updates and transmit data via submission standard QRDA I.

  • If the EP does not have Medicare data on at least 9 CQMs from 3 domains, they can electronically report the maximum number of CQMs they do have Medicare data for.
CQMs - What’s new for 2015?

• Submit Clinical Quality Measures (CQM) in accordance with the 2014 Meaningful Use Revision Final Rule

• Regardless of stage, EPs must submit CQM data for the full calendar year (January 1st, 2015-December 31st)

• EPs must report on 9 of the 64 CQMs found in the EHR Incentive Program Stage 2 CQM Measure Set

• Cover at least 3/6 National Quality Strategy domains
  – Medicare – Attest or electronically report via PQRS e-reporting mechanism
  – Medicaid – EPs must meet their home state’s requirements
Before Choosing CQMs

• Before choosing which CQMs you are going to report on, talk to your vendor.

  – Is your product certified for the following:
    • To “capture and export”
    • For “electronic submission”
    • To “import and calculate”

  – Which measures is your product certified to submit?
    • You can also check on the ONC Certified Health IT Product List at http://oncchpl.force.com/ehrcert?q=chpl

• Does you practice have any quality improvement (QI) efforts underway related to any of the CQMs?

  – If you are participating in other QI efforts, don’t reinvent the wheel; keep it easy.
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The Flexibility Rule & EHR Certification
CEHRT Changes Flexibility Rule for Meaningful Use of EHRs

• Published August 29, 2014
• Effective Mid October 2014
• Rule Provisions:
  – Allows providers to use EHRs certified to the 2011 or 2014 Edition criteria or a combination of both Editions for an EHR Reporting Period in 2014
  – Required providers to report using 2014 Edition CEHRT for EHR Reporting Period in 2015
  – Extended Stage 2 through 2016
  – EP’s who cannot meet stage 2
Flexibility Rule for Meaningful Use of EHRs

- Only available to providers who are unable to fully implement 2014 Edition CEHRT for an EHR reporting period in 2014 due to delays in 2014 Edition CEHRT availability.

- First year Medicaid participants must use 2014 Edition CEHRT in order to receive a payment for adoption, implement or upgrade for 2014 participation.
Attestation, Payment Adjustments, & Pre-/Post-Payment Audits
Attestation

• Attestation System updates will make choices easier

• Attest any time after the reporting period ends – up until 2 months after the calendar/fiscal reporting period ends

• You can enter product information into CHPL to identify Edition of CEHRT and obtain a unique certification ID
  – Entering the ID will show you what options you have for 2014
  – New attestation guide to be published

• Deadline for attestations 2/28/15
Payment Adjustments
Summary Detail

• Payment Adjustment for EPs
  - Tied to a specific year and when first entered the program
  - 1% of Medicare charges in 2015
  - 2% of Medicare charges in 2016
  - 3% of Medicare charges in 2017
  - Etc.
  - Reversal of payment adjustment for successful MU attestation in a subsequent year
Payment Adjustments
Scenario Examples

• **Scenario #1**: Provider successful in 2011 or 2012 and missed MU in 2013
  - Penalty of 1% occurs in 2015
  - If successful in 2014, penalty removed in 2016

• **Scenario #2**: Provider successful in 2011 or 2012 and 2013 now misses MU in 2014
  - Penalty of 2% comes in 2016
  - If successful in 2015, penalty removed in 2017

• **Scenario #3**: If provider successful in 2011 or 2012, 2013, 2014 and 2015 misses MU in 2016
  - Penalty in of 4% in 2018
  - If successful in 2017, penalty removed in 2019
Pre- and Post-Payment Audits

• **All** Meaningful Use attestations are subject to pre- and post-payment audits
  
  – A pre-payment audit will not exclude you from a post-payment audit
  
  – Risk strata will change from year to year for audits
  
  – An audit for one program year doesn’t prevent you from participating in the current program year

• All information submitted with an attestation is subject to audit
  
  – Keep all attestation records for a minimum for 7 years:
    
    • Eligibility data, security analyses
    
    • MU numerators & denominators, screen shots (as needed)
    
    • Exclusion and “yes/no” measure documentation
    
    • Specific requirements needed if changing vendors!
Pre-Payment Audits

Meaningful Use Audits
MU Data from HHS

5,825 PRE-PAYMENT AUDITS
3,820 (65.6%) OF PRE-PAYMENT AUDITS HAVE BEEN COMPLETED
2,005 PRE-PAYMENT AUDITS ARE STILL IN PROGRESS

21.5% OF ELIGIBLE PROVIDERS DID NOT MEET MEANINGFUL USE STANDARDS (FAILED PRE-PAYMENT AUDITS)
7.1% OF THOSE THAT FAILED "DID NOT USE CERTIFIED EHR TECHNOLOGY TO MEET MEANINGFUL USE"
92.9% OF THOSE THAT FAILED "DID NOT MEET MEANINGFUL USE OBJECTIVES AND ASSOCIATED MEASURES"

Data from HealthSecurity Solutions; November 4, 2014
Site is here

PHYSICIAN REGIONAL EVENT DINNER SERIES
Post-Payment Audits

Data from HealthSecurity Solutions; November 4, 2014
Site is here
Stage 3 Forecast

• Pure speculation!
• Preliminary Rule – end of quarter 1
• Stage 3 rules currently with the OMB
• 60 Day Review Process
• 30 Day Turnaround of Rule
• Final Rule – Early quarter 3, 2015
• Vendor preparation and release of software
  – 6 months – quarter 1, 2016
• Reporting period starts:
  – EH – October 1, 2016
Stage 3 Forecast
Based on Stage 2 Changes

• Increased thresholds
  – Examples: e-Rx, vitals, and demographics
• Increased thresholds and additional measures
  – Example: CPOE
• Menu to Core
  – Examples: immunizations
• New Measures
  – Example: patient messaging
Stage 3 Forecast
Based on MU Domains

• Improve quality, safety, efficiency, and reduce health disparities
  – Continued focus on all areas (e.g., medication and device safety)
• Engage patients and families
  – Increased ability for patient input to records
• Improve care coordination
  – Increased engagement on transitions
• Improve population and public health
  – Focus on infection, surveillance, and access to information
• Ensure adequate privacy and security protections for PHI
What You Can Start Doing Today

• Contact your EHR vendor and schedule the upgrade

• Become familiar with the new Core & Menu Objectives
  – Decide which internal workflows need to be modified
  – Educate all EPs and staff in your practice on Stage 2
  – This is a team sport!

• If attesting to Medicaid, begin preparing your eligibility documentation
  – Contact the Medicaid EHR Incentive Program Coordinator if you have questions
Resources

• HHS.GOV Meaningful Use definitions and Objectives: http://www.healthit.gov/providers-professionals/meaningful-use-definition-objectives

• HIMSS Meaningful Use One Source
Additional Resources

- EHR Incentive Programs Website
  - http://www.cms.gov/EHRIncentivePrograms/

- EHR Incentive Program Information Center
  - 888-734-6433, TTY: 888-734-656

- General Info on CQMs
Resources

CEHRT Rule Resources

» **CEHRT Interactive Decision Tool** – providers answer a few questions about their current stage of meaningful use and Edition of EHR certification, and the tool displays the corresponding 2014 options.

» **2014 CEHRT Flexibility Chart** – chart provides a visual overview of CEHRT participation options for 2014.

» **2014 CEHRT Rule Quick Guide** – guide provides corresponding resources based on the option a provider chooses for 2014 EHR Incentive Programs participation.

Thank You!

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