2015 Meaningful Use Final Rule Released

The Centers for Medicare & Medicaid Services (CMS) and Office of National Coordinator for Health Information Technology (ONC) released final rules for Meaningful Use and the 2015 Edition Health IT Certification Criteria. These new rules aim to simplify requirements and add new flexibilities to meeting Meaningful Use. These new rules will also prepare providers and consumers to be able to securely exchange health information.

The final rule makes changes to current Meaningful Use requirements by easing the reporting burden for participating providers and supporting interoperability. Major changes to the requirements include:
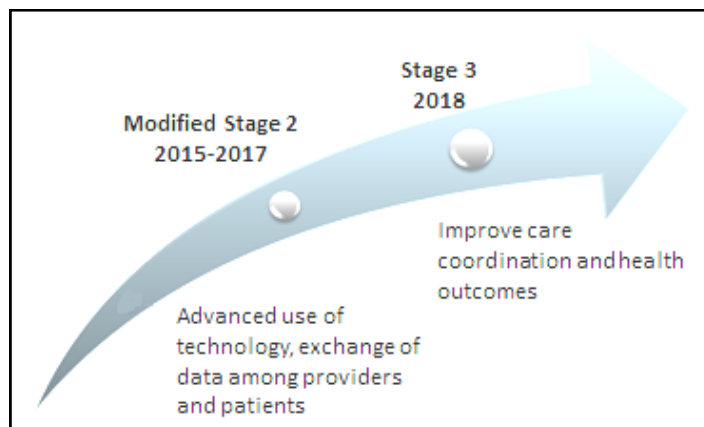
- 90-day reporting period for all eligible providers scheduled to attest for Meaningful Use in 2015
- 10 objectives for eligible providers, including one public health reporting objective – down from 18 objectives in prior stages

The requirements regarding Clinical Quality Measures (CQMs) remains as previously finalized. CMS encourages providers to apply for exemptions if they had difficulty with or needed to switch their EHRs or experienced challenges due to the timing of the rules and EHR implementation.

CMS restructured the objectives and measures of the EHR Incentive Programs in 2015 through 2017 to align with Stage 3 of Meaningful Use. CMS is continuing to evaluate where modifications can be made to align changes to Meaningful Use with the goals for Stage 3.

For Stage 3 of the EHR Incentive Programs in 2017 and subsequent years, major provisions include:

- 8 objectives for eligible professionals: In Stage 3, more than 60 percent of the proposed measures require interoperability
- Public health reporting with flexible options for measure selection

Starting in 2015, Meaningful Use will consist of a Modified Stage 2 and Stage 3

- CQM reporting aligned with the CMS quality reporting programs
- Finalize the use of application program interfaces (APIs) that enable the development of new functionalities to build bridges across systems and provide increased data access - This will help patients have unprecedented access to their own health records, empowering individuals to make key health decisions

The final rule adopts flexible reporting periods for new participants in 2016 and 2017, and for any provider moving to Stage 3 in 2017. Eligible providers that are attesting for Meaningful Use for the first time or are planning to attest for Stage 3 in 2017 will have a 90-day reporting period. The Stage 3 requirements are optional in 2017. All providers will be required to comply with Stage 3 requirements beginning in 2018 using EHR technology certified to the 2015 Edition.

NYC REACH has prepared materials that provide an overview of these changes and explain the exclusions for the new Meaningful Use updates. Please be sure to visit the NYC REACH Resource Library for more information.

In This Issue

PCIP to Collaborate with the New York State Practice Transformation Network in Helping Practices Prepare for New Payment Models

The Primary Care Information Project (PCIP) has joined the New York State Practice Transformation Network (NYSPTN) for the newly awarded Transforming Clinical Practices Initiative (TCPI) grant as a Technical Assistance provider. Funded by Centers for Medicare and Medicaid Services (CMS), TCPI is one of the largest federal investments created to support doctors and other clinicians nationwide through collaborative and peer-based learning networks. The aim of TCPI is to help practices make the clinical and business changes needed in order to thrive in the new healthcare environment. The NYSPTN is comprised of leading, trusted members of New York State's healthcare community who have come together to make sure New Yorkers benefit from this important federal program. PCIP will collaborate with the New York eHealth Collaborative (NYeC) and Finger Lakes Health Systems Agency in engaging clinicians in practice transformation and preparation for value-based payment.

TCPI is intended for primary and specialty care clinicians and practices that serve Medicaid, Medicare, and Children's Health Insurance Program (CHIP) patients. PCIP plans to enroll 2,000 clinicians in the TCPI program over the next four years, ensuring the inclusion of clinicians in medically underserved, rural or health professional shortage areas. Clinicians enrolled in TCPI will receive skilled technical assistance provided by PCIP through a combination of remote and on-site training & support at no cost, as well as peer-level support and access to national expert faculty.

> *"This support is critical to achieve better care, smarter spending, and healthier people."*

The value to clinicians enrolled in TCPI is significant, as the expectation is for each clinician to complete the program with the ability to function as a clinically integrated medical home in order to attract new payment contracts with insurance companies. Patrick Conway, MD, acting principal deputy administrator and Chief Medical Officer of CMS has said, "As a practicing physician, I know the importance of quality improvement support and sharing of best practices to help clinicians transform their practice and deliver outstanding care to every person. This support is critical to achieve better care, smarter spending, and healthier people." **– Please highlight this quote in call out box**

TCPI is one of several practice transformation sources of funding currently available in New York State, including the Delivery System Reform Incentive Payment program (DSRIP) and the State Innovation Models initiative (SIM). Clinical practices participating in various New York State programs are likely to be eligible to participate in TCPI.

If you or your practice is interested in participating in TCPI, please contact cborut@health.nyc.gov for more information about eligibility, program benefits, etc.

The estimated value of participation in TCPI for a solo-physician practice is over $92,000 annually, including additional fee-for-service revenue, from:

Wellness visit training:	~ $30,000
Transitional care training:	~ $14,000
Chronic care training:	~ $36,000
Penalty avoidance:	~ $12,000
Total	~ $92,000

Estimate for a 3-5 physician practice is more than $300,000.

Tracy Towers: Controlling Diabetes in the South Bronx

T racy Towers Medical PC, a small independent practice in the South Bronx, has successfully implemented techniques to help their patients with diabetes control their A1C levels. The practice is led by Dr. Chaula Patel, who has been a physician for over 18 years and has been working at Tracy Towers for 11 years.

In 2008, Tracy Towers Medical PC joined NYC REACH and received assistance with adopting and implementing their EHR. Dr. Patel receives a dashboard every month, which a is one-page report that demonstrates a practice's performance on quality measures such as A1C control, body mass index (BMI), and hypertension., Dr. Patel has implemented changes within Tracy Towers Medical using the information on the dashboard to improve the quality of care and manage A1C levels across her patient population.

Dr. Patel has been serving the Grand Concourse Section of the Bronx for over 18 years
Source: grandconcourse100.org

Dr. Patel is one of the top performing NYC REACH providers in the South Bronx – with less than 13% of her patients with diabetes in poor control (based on A1C level > 9%). She is currently performing above the average for the South Bronx and New York City. According to analysis from the New York City Hemoglobin A1C Registry, nearly 20% of people with diabetes in the South Bronx are in poor control. In New York City, 17% of people with diabetes are in poor control.

Dr. Patel has made controlling A1C levels and maintaining a healthy BMI a critical strategy for Tracy Towers Medical. All providers at Tracy Towers Medical have been trained to be able to independently work with patients with high A1C levels . Dr. Patel has been able to maximize her efforts of communicating lifestyle changes to her patients through modifications to workflow changes within the practice; she equips her staff with the tools to help patients make lifestyle changes needed to combat diabetes. Additionally, she joins her physician assistants when meeting with certain patients to stress the importance of healthy eating and exercising Dr. Patel dedicates extra time during her appointments to counsel patients on improving eating habits, identifying key issues and determining a plan of action together with the patient. Plans of action focus on diet and exercise, and are based on the patient's A1C level, BMI, and the patient's commitment to change. "It is important to know how much a patient is eating, and what they are eating on an average day. Food is an addiction; it is hard for people to separate what they are eating from what they should be eating," advises Dr. Patel.

Tracy Towers also implements an active approach when it comes to helping her patients control their diabetes, by ensuring these patients have follow-up appointments more frequently. Follow up appointments are scheduled for every 3 months to check in with patients and discuss their progress, and educational brochures on diet change, standard food serving sizes, and diabetes are provided. Additionally, the practice leverages local resources to help their patients with prediabetes, such as the National Diabetes Prevention Program (NDPP). Tracy Towers was one of the first practices to partner with the NDPP.

Tracy Towers Medical faces many challenges in helping their patients lower their A1C levels. Dr. Patel leverages multiple resources aligned with the Chronic Care Model of disease to help equip her patients with the best tools to control their diabetes. "It's still very difficult to manage [A1C levels], I struggle every day." Dr. Patel continues. "I plan to continue to leverage the information available to me to continue helping patients".

There are multiple community programs, like the NDPP and Diabetes Self-Management Workshops, which are available to help promote lifetstyle management of chronic diseases. Some of these community programs offer classes and provide educational resources to help patients learn how to control their diabetes. Providers can refer their patients to these workshops to assist with necessary lifestyle modifications such as dieting and exercising. The Primary Care Information Project (PCIP) can provide information on these community resources. For more information, please contact EBI_Referrals@health.nyc.gov.

Tracy Towers Diabetes Care Plan

- Counsel patients on healthy eating and exercising
- Conduct diet overview with patients
- Work with patients on goal setting

- Schedule follow-up appointments
- Provide relevant patient education
- Refer patients to relevant community resources

NYC REACH is the federally designated regional extension center (REC) for NYC founded and operated by PCIP.

Public Health Reporting in 2015

In order to successfully attest for Meaningful Use and receive an incentive payment, eligible providers must meet Public Health Objectives for their respective EHR Incentive Programs. When the Centers for Medicare and Medicaid Services (CMS) announced the Meaningful Use final rule earlier this year, EPs were given three possible options for meeting public health reporting objectives.

- Option 1 – Completed Registration or Intent to Submit Data: EPs must submit registration with a Public Health Agency *within the first 60 days of the start of their respective EHR reporting period.* The Public Health Agency will invite the EP to being testing.
- Option 2 – Testing and Validation: EP is in the process of testing and validation to electronically submit data to a Public Health Agency. EP must respond to the Public Health Agency within 30 days; failure to do so twice within an EHR reporting period will result in failure to meet the measure.
- Option 3 – Production: EP has successfully completed the testing and validation phase and is constantly electronically submitting real data to the Public Health Agency.

The Meaningful Use Registration for Public Health (MURPH) System has been updated to accept registrations from providers scheduled to meet Stage 1. The system has also been updated to allow providers to select a 90-day EHR reporting period in 2015.

For more information, please visit www.emedny.org.

Reporting for PQRS in 2015

Eligible Providers (EPs) had until December 31st, **2015** to report for PQRS in order to avoid a 2% payment adjustment in 2017. Individual EPs did not need to sign-up or pre-register in order to participate in PQRS. However, an EP must meet the criteria for satisfactory reporting specified by the Centers for Medicare & Medicaid Services (CMS) for a particular reporting period in order to qualify for a PQRS incentive payment. All EPs participating in PQRS need to report *at least* nine (9) measures.

To participate in PQRS for **2015**, individual EPs may choose to report information on individual PQRS quality measures or measure groups using the following methods:
- Medicare Part B claims (referred to as "Claim-based reporting, EPs can use this if they have not been reporting through other methods for this year)
- Qualified registry
- Direct electronic health record (EHR) using Certified EHR Technology
- Data Submission Vendor via Certified EHR Technology
- Qualified Clinical Data Registry

NYC REACH has recently created and updated resource guides for PQRS. Please visit the PQRS section of the NYC REACH Resource Library for more information.

For more information about participating in PQRS, please review the PQRS website: http://www.cms.gov/PQRS.

For additional questions, EPs should contact the QualityNet Help Desk via phone or email.

QualityNet Help Desk
Phone: 1-866-288-8912
TYY: 1-877-715-6222
Email: Qnetsupport@sdps.org

Beginning the Search for An IT Consultant

When considering Information Technology (IT) consultants for a private medical practice, it is important to address the importance of privacy and security. Because an IT consultant is likely to handle very important information, such as patient health information (PHI), private practices should obtain a Business Associate Agreement with every consultant that has access to their patient information.

For practices that are looking for additional support with finding the right IT consultant and to help start the selection process, NYC REACH has compiled a list of questions to ask any potential IT consultants:

Industry Awareness
- Have they ever had issues with data breaches?
- How many of their current clients are also healthcare providers?
- Is there a list of clients that can speak about their services?
- How many years have they worked in a healthcare setting?

Healthcare Information Knowledge
- Can they identify PHI?
- Can they name the 19 Identifiers of PHI?
- Are they aware that they and their employees are considered to be Business Associates and MUST sign a Business Associate Agreement (BAA) with your practice before they can complete any work? As a result, they can be subject to fines in the case there is a breach.
- Are they familiar with NIST standards regarding provisions for sensitive data?
- Have they performed a Security Risk Assessment as prescribed by HIPAA, and willing to share it with you?

Best Practices
- Are they willing to secure ALL administrative passwords to ALL systems with the practice? These passwords will be subject to periodic audits by the practice as well.
- Are they willing to sign a Service Level Agreement (SLA) with the practice, including sanctions if they are not met?
- If they write or develop any special software, are they willing to make all the source code available to the practice?
- If they provide backup or hosting services, can they provide proof that your practice's data will always remain within the United States and cannot be moved without permission?
- In the event that their company goes out of business, or their contract with the practice is no longer in effect, are they willing to provide documented proof they have given back or destroyed any PHI in their possession?
- Will they participate in any audits which involve technical privacy and security issues?
- How do they stay current with Federal and State regulations and do they provide updates about the regulations to you?

For more information, please contact PCIP@health.nyc.gov.

New Research Brief on Depression Screening for Primary Care Providers

The Primary Care Information Project recently released its latest research brief focusing on depression screening in the primary care setting. Depression is a widely underdiagnosed disease and primary care providers can play a critical role in depression screening and management. The brief discusses the relationship between depression and chronic medical illness, why primary care is the right context for depression screening, and how depression screening is steadily being recognized by incentive payment programs.

To view this research brief and others, please visit the NYC REACH Resource Library.

Reducing Opioid Analgesic Overdose Risk: At Your Fingertips

OpioidCalc is a free, user-friendly app to help health care providers reduce opioid analgesic-related overdose risk in their patients. This app was developed by the New York City Health Department and is available for iOS and Android.

The Problem

Opioid analgesic (prescription painkiller) misuse and overdose is a public health crisis, nationwide and in New York City.[1, 2] Across the United States, there were nearly 17,000 opioid analgesic-related overdose deaths in 2011 alone.[3] In New York City, the rate of opioid analgesic-related overdose deaths increased by 256% from 2000 to 2013, with more than one person dying every other day in 2013.[2] High opioid analgesic dosages are associated with fatal and non-fatal opioid analgesic-related overdoses.[4, 5] Specifically, opioid dosages ≥100 morphine milligram equivalents (MME) per day increase overdose risk by 9 times compared with dosages between 0 and 20 MME.[4] MME is a common unit of comparison for opioid analgesics; it expresses an opioid's strength in relation to morphine. For example, a 50 mcg fentanyl patch is 120 MME; 30mg of oxycodone taken three times daily is 135 MME.

What does the New York City Department of Health and Mental Hygiene Recommend?

The New York City Department of Health and Mental Hygiene (DOHMH) released guidelines for judicious opioid prescribing, including a recommendation to avoid high-dose (≥100 MME) opioid prescriptions. Because prescribers might lack experience with MME, DOHMH developed a smartphone app called OpioidCalc that quickly and easily calculates MME.

OpioidCalc — An App to Help

OpioidCalc is a free, mobile app for iOS and Android that calculates the total daily MME that a patient is taking, based on type of opioid analgesic, strength, and quantity. Multiple types of opioids can be included in a single calculation. OpioidCalc determines the total daily MME within seconds. If the total reaches 100 MME/day, a red alert appears indicating an increased risk for overdose and providing a link to the DOHMH opioid prescribing guidelines. In addition to informing the health care provider of increased overdose risk, the red alert graphic might also provide a visual opportunity for health care providers to initiate an educational conversation with patients at risk of overdose from opioid analgesics.

OpioidCalc is intended for use in ambulatory care settings; intravenous formulations of opioid analgesics are not included. The purpose of the app is to help assess overdose risk, not to convert from one opioid type to another. OpioidCalc is for prescribing clinicians, and may also be of use to nurses or pharmacists.

Case Example

Mr. Smith is a 70 year-old male with a history of severe back pain due to spinal stenosis. You recently inherited this patient from one of your colleagues who retired. You have your first visit with Mr. Smith today. You review Mr. Smith's history and learn that his spinal stenosis is not amenable to surgery. He is currently being treated for pain with oxycodone extended release 30mg BID and oxycodone immediate release 15mg every 4–6 hours PRN. On average, he takes one dose of oxycodone 15mg per day for breakthrough pain. You recently heard about NYC DOHMH's OpioidCalc and downloaded it to your smartphone. During the visit with Mr. Smith, you open the app and enter his opioid analgesic regimen. You are concerned to see that Mr. Smith is taking is a total of 112.5 MME/day. You discuss your concern for overdose with him. Mr. Smith understands the risks. After a conversation about alternative treatment options, you decide to safely taper Mr. Smith to an opioid analgesic regimen that is below 100 MME per day, recommend physical therapy, and initiate non-opioid treatments for his condition.

Help Decrease Risk of Overdose in Your Patients Today — Download OpioidCalc Now!

Opioid analgesic overdose death is preventable. Download OpioidCalc now and join the many health care providers who are already using the app to help reduce overdose risk in their patients.

Download the free OpioidCalc App today!

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[1] CDC Vital Signs: Overdoses of Prescription Opioid Pain Relievers — United States, 1999–2008. MMWR. 2011;60:1487–1492.

[2] Paone D, Dowell D, Heller D. Preventing Misuse of Prescription Opioid Drugs. City Health Information 2011;30(4):23–30.

[3] Chen LH, Hedegaard H, Warner M. Drug-poisoning Deaths Involving Opioid Analgesics: United States, 1999–2011. NCHS Data Brief 2014(166):1–8.

[4] Dunn KM, Saunders KW, Rutter CM, et al. Opioid Prescriptions for Chronic Pain and Overdose: A Cohort Study. Ann Intern Med 2010;152(2):85–92.

[5] Bohnert AS, Valenstein M, Bair MJ, et al. Association Between Opioid Rrescribing Patterns and Opioid Overdose-Related Deaths. JAMA 2011;305(13):1315–21.

New Resources to Prevent Older Adult Falls

F alls are a major threat to older adults' health and independence. Approximately 18,000 older adults in New York City are hospitalized each year due to falls. More than a third of those hospitalizations result in discharge to a skilled nursing facility. Even falls without injury can lower quality of life if older adults restrict their activities due to fear of falling.

Primary care providers can reduce the risk of falls by assessing all adults aged 65 and older annually for fall risk factors. The New York City Department of Health and Mental Hygiene recently released a comprehensive guide on falls risk assessment and intervention: City Health Information: Preventing Falls in Older Adults. This guide describes steps for initial falls risk assessment and stratification, further clinical evaluation, and evidence-based interventions to reduce falls risk. The guide also describes Medicare billing and incentive programs, specialty referrals, and community resources for older adults. The guide can be found at http://www.nyc.gov/html/doh/downloads/pdf/chi/chi-34-6.pdf.

If you would like a presentation on falls prevention for medical staff or others in your organization, please contact fallsprevention@health.nyc.gov.

Providers can also visit the Centers for Disease Control and Prevention's Stopping Elderly Accidents, Deaths & Injuries (STEADI) website for tools to build fall risk assessment and prevention into your practice. The website offers free CME, CNE and other continuing education activities, case studies, patient education materials and videos demonstrating validated tests for gait, balance and strength assessment.

The City Health Information (CHI) publication is an evidence-based clinical bulletin for health care providers throughout New York City. It is published electronically approximately 10 times each year, bringing timely, practical guidance on important public health topics. For more information, please visit: http://www.nyc.gov/html/doh/html/data/chi.shtml

Wearable Devices and Health Data

T he advancement of mobile and health information technology has led to the development of new wearable devices. These devices help consumers set and meet their own customizable set of goals in regards to physical activity. In order to help set and meet goals, these devices usually work with a companion smartphone application to collect information to create a user profile. A user profile could consist of the user's name, age, weight, height, telephone number, and any other information that is voluntarily submitted (meals eaten, vital signs, etc.). Some examples of other information that can be voluntarily submitted include locations of places traveled via GPS and contacts currently in the user's address book.

Gathering all of this information gives the wearable device and its parent company a better idea of who the consumer is, making the collected data Protected Health Information (PHI) as outlined in the Health Insurance Portability and Accountability Act (HIPAA). According to HIPAA, a Covered Entity is defined as a health plan, healthcare clearinghouse, or a healthcare provider. A Business Associate is considered any individual or organization that is not an employee of a Covered Entity and has access to PHI.

Please note: the organizations that develop and support these wearable devices are not governed by HIPAA because they are not considered to be Covered Entities or Business Associates. Because of this, these organizations cannot be regulated under HIPAA guidelines. It is crucial to be knowledgeable of the terms of agreement for each respective wearable device, as some may vary depending on the organization.

If using a wearable device, all information should be treated and protected as other PHI.

Prepping for Loss of Internet Access: Link Aggregation

As medical practices rely more and more on internet connectivity to use Electronic Health Records (EHRs) and other dependent systems, physicians must consider, and answer, the key question of what to do in the event of an internet outage.
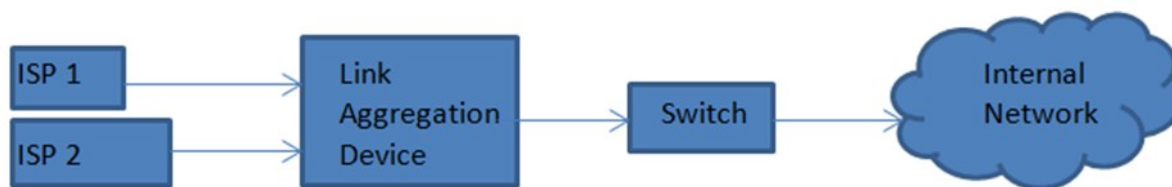
While different from fires, floods and weather-related events, internet outages can still be classified as a disaster. An applicable recovery plan should be included in a practice's disaster recovery plan. Some recovery plans include temporary stop-gap measures that include using paper charts. Collected data must be manually entered into EHRs once internet connectivity is back on-line. Setting up "internet redundancy" plans can be included in a recovery plan. A process to consider within a recovery plan is called *Link Aggregation*.

Link Aggregation requires that two or more internet service providers (ISPs) to be connected together, providing a "fault-tolerant" data pipe to the internet. If one ISP should fail, internet connectivity through the alternative ISP would still be available. When one of the ISPs fails, Link Aggregation ensures continuous internet connectivity would be available to continue normal office procedures, and the ability to continue seeing patients. Slower than normal internet speeds may be experienced when using Link Aggregation.

To support Link Aggregation as a viable disaster recovery tool, providers can consider having additional hardware in case the current setup fails. Devices that support Link Aggregation can either be a specialized device that can be purchased, or an old computer running the Linux operating system and using three network cards—one for each ISP connection and one for the local network connection. While most ISP modems have a built-in firewall, the option to add an additional firewall to link aggregation setup is also available. The Linux operating system, as well as supporting software for setting up Link Aggregation and firewalls, can be obtained for free. This solution results in a zero-cost solution if existing equipment is used, like an old computer.

Providers should also consider the combination of ISP connections. Some ISPs are wired and deliver connectivity underground through man-holes and others are set up above-ground using telephone poles. Identify which ISP is routed underground and above ground and consider utilizing one of each to limit total internet failure.

For more information, please contact NYC REACH at PCIP@health.nyc.gov or your IT consultant to see how Link Aggregation can be set up at your medical practice.