Dentists and Meaningful Use

PART TWO: STAGE 2, CQMS AND EHR-EDR INTEGRATION LOGISTICS

Adele Allison,
National Director of Government Affairs

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Certifications

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contained in the american recovery and reinvestment act of 2009 (arra), HITECH provisions for the CMS EHR Incentive Programs also known as Meaningful Use.

• The law is inclusive of the full care continuum, including oral health providers
• Under ARRA, DDS/DMDs are eligible to earn incentives through either the Medicare or Medicaid EHR Incentive Program
• Policymaking has been non-inclusive of the full care continuum, making it hard for dentists to achieve incentives
• There is a disconnect between Electronic Dental Records (EDRs) and Electronic Health Records (EHRs)
• Guidance on how dentists can embrace Meaningful Use has been limited

Contained in this White Paper:

• Moving from Stage 1 to Stage 2 Meaningful Use
• Addressing Clinical Quality Measures (CQMs)
• Logistics of Integrating EHR-EDR technologies
• Stage 3 Policymaking Preview
Moving from Stage 1 to Stage 2

Any time a clinical setting is sorting out practice re-design using any type of health IT, there is a six-step process that should be adopted, including:

1. **Assessment** of the current practice, needs, goals – including those beyond Meaningful Use (MU) – and readiness both financially and technically.

2. **Plan** by using the information gathered in the assessment to plot the implementation roadmap.

3. **Adopt** the right technology(ies), insuring they are both certified and meet the aims of the practice’s providers and staff.

4. **Train and go live** on the new workflows with proficiency.

5. **Achieve** by measuring key analytics and performance metrics to make certain that identified goals are being reached.

6. **Continue quality improvement** by using the achieved measures to define a strategy of ongoing process development, expansion of technology and adoption of new features to help the practice better serve the patient.

The CMS EHR Incentive Programs or Meaningful Use (MU) are provisioned within legislation known as the Health Information Technology for Economic and Clinical Health Act (HITECH), enacted as part of the American Recovery and Reinvestment Act of 2009 (ARRA). The Congressional intent of this law was to accelerate and reward the adoption of interoperable and certified electronic health record technology (CEHRT). The MU programs launched in Jan. 2011, and as of the end of 2012, more than $10.4 billion has been paid to eligible professionals (EPs) and eligible hospitals (EHs) in Medicare and Medicaid incentives.1

As established in more detail in the companion paper, Part I to this series, the law contemplates broad inclusion of health care professionals including physicians, dentists, chiropractors, podiatrists, optometrists, nurse practitioners, mid-wives, and physician assistants. The Medicare and Medicaid MU programs are mutually exclusive, meaning each EP must choose which program they plan to pursue. Dentists are eligible under the law to participate in either program; however, due to the fact that Medicare does not cover general dentistry and the incentive is based upon the EP’s annual Medicare claims, it would be the extremely rare circumstance that a dentist would pursue the Medicare MU program.

This essentially limits the dental EP to participation in the Medicaid MU program. The Medicaid MU program is administered by each individual state, meaning there can be small points of variance from state-to-state. ARRA
required each state to submit and receive approval on a State Medicaid HIT Plan (SMHP) to CMS outlining activities over the next five years related to ARRA, including details on the administration of the Medicaid MU program. EPs must qualify each year for the MU incentives. This means that the dentist must meet his/her state requirements for the 30 percent patient volume to be eligible for incentives each year of participation. Dentists should consult their state Medicaid websites for specific details. CMS offers a state milestone and resource guide providing direct links to each state’s EHR Incentive Program web page.

Under the Medicaid MU program, EPs receive the largest incentive payment of $21,250 for the first year of participation by meeting the requirements to adopt, implement, or upgrade (AIU) certified EHR technology (CEHRT). In the second year of participation the EP must perform 90 continuous days of Stage 1 meaningful use to receive incentives totaling $8,500. Each subsequent year, except for CY2014, the EHR reporting period for MU is a full calendar year. Each EP will perform two years in each stage of meaningful use. Because Stage 2 launches in CY2014, EPs performing the first year of Stage 2 or the second year of Stage 1 would have an EHR reporting period of three months, defined by quarter (Jan-Mar; Apr-Jun; Jul-Sep; Oct-Dec) for the federal Medicare program; defined by each individual state as either 90 continuous days or three-month quarters.

**CMS Stage 2 Final Rule**

The final rule for Stage 2 MU was released to the public on Aug. 23, 2012, and published in the Federal Register on Sept. 4, 2012. CMS seeks to use the Stage 2 requirements as an opportunity to expand the meaningful use results achieved in Stage 1 through a broader infrastructure and a focus on the use of health IT to improve quality, efficiency and patient safety. Stage 2 MU will not be available to providers until CY2014. As stated above, for 2014 only EPs will have a three-month reporting period. The purpose is to allow up to an additional nine months for CEHRT upgrades to the 2014 Edition certification. Even EPs seeking Stage 1 compliance of the MU Programs will have to utilize 2014 Edition CEHRT (See How Certified EHR Technology is Defined in Part I).

Each EP seeking Meaningful Use Stage 2 incentives is asked to meet a total of 20 of the 23 objectives and measures. These measures break down into 17 core measures (tasks) and six menu measures from which each EP would choose three. As in Stage 1, the Stage 2 requirements offer exclusions that can be exercised by an EP where there exists irrelevance to the specialty, scope of practice and/or an insurmountable technical barrier. EPs who can exercise an exclusion clause would have a reduction in the number of measures required.

EPs must also submit nine Clinical Quality Measures (See Clinical Quality Measures and Dentists below). The following table sets forth the 17 core and six menu Stage 2 measures beginning in CY2014, as modified by CMS, with potential exclusions that may be exercised by a dental EP.
<table>
<thead>
<tr>
<th>No.</th>
<th>Objective</th>
<th>Measure</th>
<th>Threshold</th>
<th>Dental EPs Should Perform?</th>
<th>Exclusions</th>
<th>Health IT Needs</th>
</tr>
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</table>
| 1   | **Computerized Physician Order Entry (CPOE)**                            | Use CPOE for medications, lab and radiology orders entered by any professional permitted by law | 60% Rx (up from 40%); 30% labs; 30% radiology | Likely                     | EP has < 100 Rx, lab, radiology orders collectively                                                  | • Orders management  
• Orders audit trails  
• Delinquency alerts |
| 2   | **Generate and Transmit Permissible Prescriptions Electronically**         | Using a certified EHR technology and compared to at least 1 drug formulary (still excludes controlled substance [Sch. II-V] and OTC) | 50% (up from 40%)                             | Maybe                      |                                                                                                     | • Rx database  
• Interaction alerting  
• eRx (e.g., Surescripts)  
• Formulary checking |
| 3   | **Record Patient Demographics**                                           | Gender, race, ethnicity, DOB, and preferred language as structured data  | 80% (up from 50%)                             | Yes                        | None                                                                                                | • Patient administration  
• Master patient index |
| 4   | **Record Vital Signs and Chart Changes**                                 | Height & weight (all ages), blood pressure (ages 3+), BMI (all ages), and growth charts for children (0-20) as structured data | 80% (up from 50%)                             | No (BP may apply)           | • No pts. age 3+  
• Ht., Wt., BP irrelevant  
• BP only irrelevant                                           | • Vitals capture tool  
• Detailed entry  
• Normal ranges and graphing  
• Automated BMI and growth charts |
| 5   | **Record Smoking Status**                                                 | Patients age 13 and older as structured data                             | 80% (up from 50%)                             | Likely                     | EP does not see pts. age 13+                                                                        | • Smoking status  
• Alerting to lack of documentation |
| 6   | **Implement Clinical Decision Support and Track Compliance**              | Implement CDS to improve on high-priority condition:  
1. 5 CDS interventions for 5 or more CQMs during entire reporting period; and  
2. Enable drug-drug and drug-allergy checks for entire reporting period. | 5 Rules and Rx alerting by attestation        | Yes (Part 1) Maybe (Part 2) | 2nd measure only – EP writes < 100 Rx                                                                 | • Evidence-based guidelines  
• Population management tool  
• Point-of-care alerting for non-adherence  
• Static and customizable interventions |
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<tbody>
<tr>
<td>7</td>
<td><strong>Incorporate Clinical Lab Test Results into EHR</strong></td>
<td>Incorporated as structured data – positive/negative or numerical format – within the EHR</td>
<td>55% (up from 40% and made Core)</td>
<td>Maybe</td>
<td>EP orders no lab tests during EHR reporting period</td>
<td>• Bidirectional lab Interface for in-house and/or reference labs</td>
</tr>
<tr>
<td>8</td>
<td><strong>Generate Lists of Patients by Condition</strong></td>
<td>1 List with a Specific Condition for use in quality improvement, reduction of disparities, research or outreach</td>
<td>By attestation (Made Core)</td>
<td>Yes</td>
<td>None</td>
<td>• Evidence-based guidelines • Population management tool • Action tracking and escalation • Patient portal alerting • Form letter merging • Phone lists</td>
</tr>
<tr>
<td>9</td>
<td><strong>Send Reminders to Patients</strong></td>
<td>Preventive and follow-up care for all patients based on clinically relevant info for anyone with an OV in past 24 months</td>
<td>10% (down from 20%, all patients and made core)</td>
<td>Likely</td>
<td>EP has no office visit in previous 24 months</td>
<td>• Evidence-based guidelines • Population management tool • Action tracking and escalation • Patient portal alerting • Form letter merging • Phone lists</td>
</tr>
<tr>
<td>10</td>
<td><strong>Timely Electronic Access to Health Information</strong></td>
<td>Patients can view online, download and transfer info within 4 days of being available to EP, subject to EPs discretion to withhold certain info</td>
<td>1. 50% of all pts., and 2. 5% of pts. access</td>
<td>Likely</td>
<td>• EP has no orders / creates info required • &gt;50% visit in county with &gt;50% with 3Mbps broadband avail.</td>
<td>• Advanced patient portal • Robust portal integration to CEHRT • Access tracking • Patient administration</td>
</tr>
<tr>
<td>11</td>
<td><strong>Provide Patients with Clinical Summaries</strong></td>
<td>For each office visit to patients <strong>within 1 business day</strong>, which includes up-to-date lists of problems, medications and Rx allergies (paper &amp; electronic must be avail. to pt.)</td>
<td>50% (Unchanged)</td>
<td>Yes</td>
<td>EP has no office visit during EHR reporting period</td>
<td>• Advanced patient portal • Robust integration of portal to CEHRT</td>
</tr>
<tr>
<td>No.</td>
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<tr>
<td>12</td>
<td>Use of Secured Messaging with Patients</td>
<td>Send secured messages to patients seen during reporting period</td>
<td>5%</td>
<td>Yes</td>
<td>EP has no office visit during EHR reporting period</td>
<td>• Advanced patient portal</td>
</tr>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Messaging capabilities</td>
</tr>
<tr>
<td>13</td>
<td>Use EHR for Patient-Specific Education Resources</td>
<td>Provide patient-specific education resources to all patients</td>
<td>10%</td>
<td>Yes</td>
<td>EP has no office visit during EHR reporting period</td>
<td>• Integrated patient education tools</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Static and customizable forms</td>
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<td></td>
<td></td>
<td></td>
<td>• Multi-language</td>
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<tr>
<td>14</td>
<td>Perform Medication Reconciliation</td>
<td>During transitions of care (TOC) into care of EP</td>
<td>50%</td>
<td>Maybe</td>
<td>EP not recipient of any TOC during EHR reporting period</td>
<td>• HIE (Direct or Exchange)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Rx history</td>
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<tr>
<td>15</td>
<td>Provide Summary of Care Record</td>
<td>Patients referred or transitioned to another provider or setting and electronically transmit to a different system.</td>
<td>1. 50% of TOC or referrals (made core) 2. 10% electronically transmitted</td>
<td>Maybe</td>
<td>EP neither transfers nor refers patient during EHR reporting period &lt;100 times</td>
<td>• CCDA</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• HIE (Direct or exchange)</td>
</tr>
<tr>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td>• HIE tracking</td>
</tr>
<tr>
<td>16</td>
<td>Submission of Electronic Immunization Data to Registry/Information Systems</td>
<td>Ongoing submission</td>
<td>During Entire EHR Reporting Period (Made Core)</td>
<td>No</td>
<td></td>
<td>• Immunization registry interface or HIE submission to immunization registry</td>
</tr>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• CEHRT immunization guideline adherence tracking tool</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Detailed immunization tool</td>
</tr>
<tr>
<td>17</td>
<td>Implement Systems to Protect Privacy and Security of Patient Data</td>
<td>Conduct/revew a security risk analysis; implement security updates as necessary and correct security deficiencies; encrypt data at rest in accordance with 45 CFR 164.312(a) (2)(iv) and 45 CFR 164.306(d)(3)</td>
<td>During Reporting Period by attestation</td>
<td>Yes</td>
<td>None</td>
<td>• Thin-client CEHRT operations</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Encryption technology</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td>• (Optional) data-hosting</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Internet access</td>
</tr>
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</table>

*Exclusion does not apply if the registry can accept data through a designated HIE.*

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Dental EPs must perform three of the six available Menu Objectives and cannot limit the selection of the three to those wherein an exclusion clause can be exercised. In other words, an EP cannot select a menu item simply because he/she can be excluded. Practices should be aware that CMS has stated in the final rule its intent to propose that every objective/measure in the Stage 2 menu set be included in Stage 3 as part of the core set, and begin positioning accordingly.

### 3 of 6 Menu Objectives

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| 1   | **Imaging Results and Information**                 | Are accessible through the CEHRT             | 10%       | Yes                       | • EP does not perform diagnostic interpret. of scans/test whose result is an image during reporting period, or  
  • EP orders imaging results < 100 times                                      | • PACS results interface  
  • PACS portal for image retrieval                                               |
| 2   | **Patient Family Health History**                   | Structured data entry for one or more first-degree relatives | 20%       | Yes                       | EP has no office visits during reporting period                             | • Structured knowledge base for documentation  
  • Family health history clinical concepts                                         |
| 3   | **Record Electronic Notes**                         | At least 1 note created, edited and signed by EP for pts with at least 1 OV during EHR reporting period | 30%       | Likely                    | • No office visits during reporting period, or  
  • >50% visit in county with >50% with 3Mbps broadband access                 | • Structured knowledge base for documentation,  
  • Voice recognition,  
  • Customizable forms, and/or  
  • Ability to type note                                                            |
| 4   | **Submission of Electronic Syndromic Surveillance Data** | Ongoing data submission to Public Health agencies (where agencies can accept electronic data) | During Entire EHR Reporting Period | Maybe                    | • EP does not collect any data,  
  • No electronic registry available*  
  • No timely provision of information on available registry  
  • No registry that accepts CEHRT standards available*                           | • Public health registry interface or HIE submission to public health registry  
  • CEHRT surveillance tracking tools                                               |
<table>
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</table>
| 5   | Submission of Cancer Cases         | Ongoing data submission to a state cancer registry | During Entire EHR Reporting Period             | Maybe                     | • EP does not diagnose or directly treat CA  
• No public health agency is capable of receiving data  
• No timely provision of information on available registry  
• No registry that accepts CEHRT standards available | • State cancer registry interface or HIE submission to state cancer registry  
• CEHRT cancer tracking tools                                                                                                                                                                           |
| 6   | Submission of Specialized Cases    | Ongoing data submission to a specialized registry | During Entire EHR Reporting Period             | Maybe                     | • EP does not diagnose or directly treat CA  
• No public health agency is capable of receiving data  
• No timely provision of information on available registry  
• No registry that accepts CEHRT standards available | • Specialized registry interface or HIE submission to specialized registry  
• CEHRT specialized case tracking tools                                                                                                                                                                |
Clinical Quality Measures

All providers are required to report on Clinical Quality Measures (CQMs) as part of demonstrating meaningful use. It is no longer an individual measure because it is intrinsic with the EHR Incentive Programs and expected. There will be no change in CQMs through 2013. Therefore, prior to 2014 EPs must submit six of a total 44 available CQMs chosen from a set of three core or alternative core and three menu measures through manual attestation. For CY 2014 and beyond, all EPs regardless of the stage of meaningful use must perform an electronic submission of nine out of a total 64 available CQMs that includes one measure in three of six National Quality Strategy domains, at a minimum. CMS has created a recommended, but not required, core set of CQMs for the adult population and a separate core set for the pediatric population. The core pediatric set of CQMs includes one of two approved oral health measures – care for children who have dental decay or cavities. They have also prioritized the National Quality Strategy domains, as follows:

1. Patient and Family Engagement
2. Patient Safety
3. Care Coordination
4. Population and Public Health
5. Efficient Use of Healthcare Resources
6. Clinical Processes/Effectiveness

CMS provides a complete list of the 2014 CQMs at http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/EP_MeasuresTable_Posting_CQMs.pdf. Reporting and submission periods for EPs in their first year of meaningful use submitting CQMs will be via attestation, with Medicaid EPs continuing to submit CQMs through their state-based attestation system. CQMs must be submitted electronically beginning in CY2014. Each state Medicaid agency is responsible for sharing the ins and outs of this electronic process with its provider community. In addition to the process, the state can set forth the timeline, subject to CMS’ prior approval.

All Medicaid EPs should be aware that CMS has invested years of time and revenue, as has the vendor community, in developing an electronic CQM data submission standard. The standard is known as the Physician Quality Reporting System (PQRS). Launched by CMS in 2007 in accordance with Bush-era legislation, clinical quality reporting was initially facilitated through claims using Quality Data Codes (QDCs) that were collected and analyzed. In 2008 and 2009, CMS began testing submission of clinical quality data submitted directly from their EHR. Known as EHR Direct, the first launch of direct submission was in early 2011 for 2010 clinical data.

Under the Affordable Care Act (ACA), CMS must align clinical reporting under meaningful use with other reporting programs including PQRS and ePrescribing. The Stage 2 final rule will put PQRS and CQMs on the same path. As
everyone knows, Medicaid is state run and under the final rule each agency is granted broad discretion in the method, process and timelines for electronic submission of clinical data. The danger lay in individual state Medicaid Agencies seeking a “one-off” version of what the federal government has already developed for EHR Direct. EHR vendors have poured literally thousands of man-hours into the EHR Direct technical specifications for the Medicare patient. If a Medicaid agency endorses a different technical standard, there will be substantial costs associated with development and delays in rapid implementation to conform to the 2014 timelines for MU. All Medicaid MU EPs need to respond to the call to action and request that their state agency look to the groundwork already completed by CMS with EHR Direct.

The issue before dentists is even broader than the transport standard for electronic submission. Dentists must submit CQMs for meaningful use compliance regardless of the stage. Until CY2014, EPs must report six total CQMs – three selected from a set of core/alternative core and three selected from a remaining menu set of 44 measures. Not surprisingly, none of the measures is oral health related. However, before 2014, CMS has recognized that the 44 measures do not marry with a wide range of specialties and provider types. Therefore, if an EP does not typically collect information on any of the required and/or menu measures, CMS states in its frequently asked questions:

“EPs are not excluded from reporting clinical quality measures, but zero is an acceptable value for the CQM denominator. If there were no patients who met the denominator population for a CQM, then the EP would report a zero for the denominator and a zero for the numerator. For the core measures, if the EP reports a zero for the core measure denominator, then the EP must report results for up to three alternate core measures (potentially reporting on all 6 core/alternative core measures). For the menu-set measures, we expect the EP to report on measures which do not have a denominator of zero. If none of the measures in the menu set applies to the EP, then the EP must report on three of such measures, reporting a denominator of zero, and then attest that the remainder of the menu-set measures have a value of zero in the denominator. As we stated in the final rule (75 FR 44409-10): ‘The expectation is that the EHR will automatically report on each core clinical quality measure, and when one or more of the core measures has a denominator of zero then the alternate core measure(s) will be reported. If all six of the clinical quality measures in Table 7 have zeros for the denominators (this would imply that the EPs patient population is not addressed by these measures), then the EP is still required to report on three additional clinical measures of their choosing from Table 6 in this final rule. In regard to the three additional clinical quality measures, if the EP reports zero values, then for the remaining clinical quality measures in Table 6 (other than the core and alternate core measures) the EP will have to attest that all of the other clinical quality measures calculated by the certified EHR technology have a value of zero in the denominator, if the EP is to be exempt from reporting any of the additional clinical quality measures (other than the core and alternate core measures) in Table 6.’”

While this allows a dentist to clear the 2013 CQM hurdle, in 2014 EPs must submit on nine total measures regardless of their MU stage. CMS gives preference in choosing its CQMs to NQF-endorsed measures. The National Quality Forum (NQF) is a nonprofit, nonpartisan, public service organization that reviews, endorses and recommends use of standardized healthcare performance measures. Through legislative authority, NQF convened the Measure Applications Partnership to advise governmental and commercial payers on measures for payment and accountability programs, an overarching theme of health care reform. In fact, NQF states that by 2017, 9 percent of all Medicare payments will be performance-based under the Affordable Care Act’s value-based modifier. NQF averages three years to endorse a measure.
The National Network for Oral Health Access (NNOHA) went to bat for oral health providers and identified six measures that made sense for NQF endorsement, complete with recommended numerators and denominators for performance measurement. In August 2011, four were endorsed by NQF and recommended by HRSA for Stage 2 meaningful use:

1. Annual Oral Health Visit
2. Children who receive preventive dental care
3. Primary caries prevention intervention as part of the well or sick child care as offered by primary care medical providers
4. Children who have dental decay or cavities

CMS approved only two oral health measures to be included in the 64 finalized CQMs in the Stage 2 final rule:

1. Primary Caries Prevention (FV as part of EPSDT) – NQF 1419, and
2. 6-month exams on children ages 1-17 – NQF 1335

EPs need to seek the remaining seven CQMs for which they capture data. Nevertheless, as in the FAQ cited above, the Stage 2 final rule CMS states:

“If an EP’s CEHRT does not contain patient data for at least 9 CQMs covering at least 3 domains, then the EP must report the CQMs for which there is patient data and report the remaining required CQMs as “zero denominators” as displayed by the EP’s CEHRT. If there are no CQMs applicable to the EP’s scope of practice and patient population, EPs must still report 9 CQMs even if zero is the result in either the numerator or the denominator of the measure. If all applicable CQMs have a value of zero from their CEHRT, then EPs must report any 9 CQMs from Table 7 [Summary of EP CQM-Specific Comments and Rationale to Finalize or not Finalize the CQM].”
This means that dental EPs should seek measures in 2014 for which they may be capturing data to report; alternatively, they would report zeros. Among the 64 Stage 2 final rule CQMs, the following may have data potential for the dentist:

- Adult Core Measure: Controlling High Blood Pressure (NQF 18)
- Adult Core Measure: Preventive Care and Screening – Tobacco Use Screening and Cessation Intervention (NQF 28)
- Adult Core Measure: Documentation of Current Medications in the Medical Record (NQF 419)
- Adult Core Measure: Preventive Care and Screening – Body Mass Index (BMI) Screening and Follow-up (NQF 421)
- Preventive Care and Screening: Screening for High Blood Pressure and Follow-up Documented (NQF TBD)

EDR-EHR Integration Logistics

As discussed in Part I of this series, an electronic dental record (EDR) must incorporate an EHR in order to be an ONC-recognized 2011 Edition CEHRT for Stage 1 since there are no dental-specific measures. The same will be true for the 2014 Edition ONC certification for Stage 2. EDRs that have received ONC certification have done so by partnering with select certified EHR systems to satisfy the MU requirements (See Electronic Dental Record v. CEHRT in Part I).

But let us look beyond simple compliance with MU. As health care reform works to shift the paradigm to patient-centered care, oral health must become more closely integrated into the care continuum for communication and system-level holistic clinical coordination. The patient must have the ability to move seamlessly from one point in the care continuum to another regardless of whether that service is available locally, across town or outside the state lines. This is a cornerstone of quality.

Health information exchange (HIE) will play a crucial role in connecting our disjointed delivery system. Yet, dentists practicing in standalone clinics will need an integrated EHR to facilitate patient-centered operations with the health care community. Poor oral health can be linked to an increase in risk for chronic diseases, such as cardiovascular disease and diabetes, as well as economic and social barriers caused by lost time due to dental problems. Additionally, in delivery sites where dental and medical care reside in a common location, such as a community health center, tight integration between the two not only makes quality sense, but also makes business sense.
Meaningful use is an opportunity for dentists to begin achieving this integration with the medical side at the practice and/or the community levels. To map the ideal points of integration between an EDR and EHR technologies, the following table identifies the strongest technology to lead assimilation for purposes of MU measurement and threshold compliance:

<table>
<thead>
<tr>
<th>MU Workflow</th>
<th>EHR</th>
<th>EDR</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Computerized Provider Order Entry (CPOE)</td>
<td>X</td>
<td></td>
<td>Primarily integration of medications and radiology orders</td>
</tr>
<tr>
<td>ePrescribing</td>
<td>X</td>
<td></td>
<td>eRx is an inherent technology for EHRs</td>
</tr>
<tr>
<td>Patient Demographics</td>
<td></td>
<td>X</td>
<td>MPI should reside in the EHR for dental/medical practices (E.g., CHCs); MPI will typically reside in the EDR for standalone dental clinics for MU.</td>
</tr>
<tr>
<td>Vitals (where relevant such as BP)</td>
<td></td>
<td></td>
<td>Dentists can likely exercise an exclusion clause although more are taking BP to identify issues of hypertension</td>
</tr>
<tr>
<td>Smoking Status</td>
<td>X</td>
<td></td>
<td>EHR for dental/medical practices; EDR for standalone dental clinics</td>
</tr>
<tr>
<td>Clinical Decision Support Technologies (e.g. Population Intervention Rules; Rx Alerting)</td>
<td></td>
<td>X</td>
<td>EHRs offer robust clinical decision support and will be required to incorporate evidence-based guidelines</td>
</tr>
<tr>
<td>Lab Results</td>
<td></td>
<td></td>
<td>Stage 2 Core requirement; Dentists may be able to exercise an exclusion clause</td>
</tr>
<tr>
<td>Generating Lists of Patients by Condition to disparity reduction, outreach and/or quality improvement</td>
<td></td>
<td>X</td>
<td>EHR for dental/medical practices since population management is a strong EHR technology; may reside in EDR for standalone dental clinics</td>
</tr>
<tr>
<td>Patient Reminders for Care</td>
<td></td>
<td>X</td>
<td>EHRs are inherently strong in population management</td>
</tr>
<tr>
<td>Timely Electronic Access to Health Information</td>
<td></td>
<td></td>
<td>Patient Portal should be core to EHR technology</td>
</tr>
<tr>
<td>Providing Patients with Clinical Summaries</td>
<td></td>
<td></td>
<td>Clinical summaries must include an up-to-date list of problems, medications and allergies – intrinsic to EHRs</td>
</tr>
<tr>
<td>Secruted Messaging with Patients</td>
<td></td>
<td>X</td>
<td>This will be an expected feature for 2014 Edition EHR certification</td>
</tr>
<tr>
<td>Patient-Specific Education Resources</td>
<td></td>
<td></td>
<td>EHRs will typically integrate patient education with Patient Portals</td>
</tr>
<tr>
<td>Medication Reconciliation when receiving a transition of care</td>
<td></td>
<td></td>
<td>Medication database and eRx are advanced technologies in EHRs</td>
</tr>
<tr>
<td>MU Workflow</td>
<td>EHR</td>
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<td>Comments</td>
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<tr>
<td>----------------------------------------------------------------------------</td>
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</tr>
<tr>
<td>Summary of Care Record when referring a patient to another provider or setting; and, electronic transmission</td>
<td>X</td>
<td></td>
<td>ONC HIE standards are being incorporated into EHR technology for advance interoperability</td>
</tr>
<tr>
<td>Implementation Systems to Protect Privacy and Security of Patient Data</td>
<td></td>
<td>X</td>
<td>All technology must be HIPAA compliant</td>
</tr>
<tr>
<td>Accessing Imaging Results</td>
<td>X</td>
<td></td>
<td>Dental imaging must be measured in the EHR for MU reporting, but viewable in the EDR</td>
</tr>
<tr>
<td>Recording Patient Family Health History as structured data</td>
<td></td>
<td>X</td>
<td>Must be reportable data; intrinsic to EHRs</td>
</tr>
<tr>
<td>Recording Electronic Notes</td>
<td>X</td>
<td></td>
<td>Primary dental charting will be performed in the EDR; however, some components may be performed in the EHR (e.g. Family Health History). Also, EHR should be capable of integrating EDR charted information into a comprehensive health record overview or summary view for all clinicians.</td>
</tr>
<tr>
<td>Submission of Syndromic Surveillance Data to Public Health Agencies</td>
<td>X</td>
<td></td>
<td>EHR technology is being armed with surveillance tracking tools and reporting capabilities.</td>
</tr>
<tr>
<td>Submission of Cancer Cases and Specialized Cases to Registries</td>
<td>X</td>
<td></td>
<td>ONC HIE standards are being incorporated into EHR technology for advanced interoperability; and it must be reportable data, which is intrinsic to EHRs</td>
</tr>
</tbody>
</table>
Additionally, dentists should consider exploring the following with vendors when seeking to integrate EHR and EDR technologies:

1. The technology should be seamless enough to offer a single sign-on.

2. If part of a safety-net clinic, the billing should provide automated household assessment and sliding fee scheduling capabilities.

3. Billing must be integrated from a single point if medical care is part of dental clinic enterprise and practice scope of services.

4. Be sure to explore tools that facilitate population management as this will be pivotal in delivering quality and succeeding with performance-based reimbursement under health care reform.

5. The integration should deliver a single point for “chart overview” – single view with medical and dental overview info combined.

In Conclusion

Integrating medical and oral health care is common sense for a number of reasons. Whether the dentist is seeking incorporation into the broader care community or simply primary care clinic operations, systemic results in quality are bound to be achieved by sharing information, providing collaborative diagnostic services and consulting the patient’s more expansive care team in a sustained fashion. Meaningful use is merely a trigger to create tighter integration between dental and medical professionals for true patient-centered care.

Embracing the cornucopia of technologies emerging in the clinical realm today can lead all members of an integrated delivery system to identify precursors to conditions and diseases as well as create health care effectiveness and operational efficiency. There is much to be done, but that means there is also much that can be accomplished!
References


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