A Guide to Healthcare Buzzwords and What They Mean: Part Two (M through Z)

Meaningful Use (MU)

Meaningful Use is the phrase used in the 2009 HITECH Act to describe the standard providers must achieve to receive incentive payments for purchasing and implementing an EHR system. The term meaningful use combines clinical use of the EHR (i.e. ePrescribing), health information exchange, and reporting of clinical quality measures. Achieving meaningful use also requires the use of an EHR that has been certified by a body such as CCHIT, Drummond Group, ICSA Laboratories, Inc. or InfoGuard Laboratories, Inc. The term can also apply informally to the process of achieving the standard, for example “How is our practice doing with meaningful use?”

mHealth

An abbreviation for Mobile Health, mHealth is a blanket label for transmitting health services, and indeed practicing medicine, using mobile devices such as cell phones and tablets. mHealth has large implications not only for newer devices like smartphones and high-end tablets, but also for feature phones and low-cost tablets in developing nations. Many different software and hardware applications fit under the umbrella of mHealth so the term is used conceptually to talk about future innovations and delivery systems.

NLP

An acronym for Natural Language Processing, NLP is a field of study and technology that seeks to develop software that can "understand" human speech – not just what words are being said, but what is meant by those words. By "processing" text input into an NLP program, large strings of text can be parsed into more traditionally meaningful data. For example, narrative from a doctor in a medical record could be transferred into data for research and statistical analysis. If we had every medical record and narrative in history, we could search it and look for trends – and possible new cures and symptoms. IBM's famous Watson machine that could "listen" to Jeopardy! clues and answer is an advanced example of NLP.

ONCHIT

An acronym for "Office of the National Coordinator for Healthcare Information Technology," the ONCHIT is a division of the Federal Government's Department of Health and Human Services. The Office oversees the nation's efforts to advance health information technology and build a secure, private, nationwide health network to exchange information. Although the National Coordinator position was created by executive order in 2004, the Office and its mission were officially mandated in the 2009 HITECH Act as a part of the stimulus package.

Patient Engagement

Patient Engagement is a broad term that describes the process of changing patient behaviors to promote wellness and a focus on preventative care. "Engagement" can roughly be read to describe the patient's willingness to be an active participant in their own care and to take responsibility for their lifestyle choices. Patient Engagement efforts can be as simple as marketing campaigns for public heath and appointment reminders, and as advanced as wearable monitors that can transmit activity and exercise information so patients can

track their fitness. Improving the health system's ability to engage patients is considered key to lowering healthcare spending and attacking epidemics like obesity and heart disease.

Patient Portal

A patient portal is software that allows patients to interact, generally through an internet application, with their healthcare providers. Portals enable communication between providers and patients in a secure environment with no fear of inappropriate disclosure of the patient's private healthcare information. Patients can get lab results, request appointments and review their own records without calling the provider. Patient portals can be sold as a standalone software module or as part of a comprehensive Practice Management/EHR package.

Patient-centered Care

Patient-centered care is a healthcare delivery concept that seeks to use the values and choices of the patient to drive all the care the patient receives. As elementary as it sounds, developing a culture that places the needs and concerns of the patient – the whole patient – at the center of the decision-making process is a new development in the healthcare system. Patient engagement is at the core of patient-centered care, because the patient is the central driver of the decisions – as is only right!

PCMH

An acronym for Patient Centered Medical Home, a PCMH is a model for healthcare delivery where most or all of a patient's services for preventative, acute and chronic primary care are delivered in a single place by a single team to improve

patient outcomes and satisfaction as well as lower costs. PCMHs may also operate under a different reimbursement structure, as they can be paid on an outcome basis or on a capitation model as opposed to fee-for-service.

PHR

An acronym for a “Personal Health Record,” a PHR is a collection of health data that is personally maintained by the patient for access by caregivers, relatives, and other stakeholders. As opposed to the EHR model, in which a single hospital or system collects all the health information generated in the facility for storage and exchange with other providers, the PHR is maintained, actively or passively with mobile data capture or sensor devices, by the patient. The PHR can supplement or supplant other health records depending on the way it is used.

PPACA

An acronym for the “Patient Protection and Affordable Care Act,” the PPACA was a federal law passed in 2010 to reform the United States healthcare system by lowering costs and improving access to heath insurance and healthcare. The PPACA uses a variety of methods – market reforms to outlaw discrimination based on gender or pre-existing condition, subsidies and tax credits for individuals, families and employers, and an individual mandate forcing the uninsured to pay penalties – to increase access to insurance and lower healthcare costs.

PQRS

An acronym for the “Patient Quality Reporting System,” PQRS is a mechanism by which Medicare providers submit clinical quality and safety information in exchange for incentive payments. Physicians who elect not to participate or are found

unsuccessful during the 2013 program year, will receive a 1.5 percent Medicare payment penalty in 2015, and 2 percent Medicare payment penalty every year thereafter.

RAC

An acronym for “Recovery Audit Contractor,” a RAC is a private company that has been contracted by the Centers for Medicare and Medicaid Services to identify and recover fraudulent or mistaken reimbursements to providers. There are four regions of the United States, each with its own RAC which is authorized to recover money on behalf of the Federal Government. A pilot program between 2005 to 2007 netted nearly $700 million dollars in repayments and the program was made permanent nationwide in 2010.

REC

An acronym for “Regional Extension Center,” a REC is a organization or facility funded by a federal grant from the Office of the National Coordinator for Health Information Technology to provide assistance and resources to providers who want to adopt an EHR and achieve meaningful use but need technical or deployment support to get their system up and running. There are currently 62 RECs in the United States who focus primarily on small and individual practices, practices without sufficient resources, or critical access and public hospitals that serve those without coverage.

Registry

A Registry is a database of clinical data about medical conditions and outcomes that is organized to track a specific subset of the population. Registries are important to track the efficacy of drugs and treatment, as well as to analyze and identify possible treatment and policy opportunities to improve care. A registry can also be used to report PQRS.

Telehealth

Telehealth is a broad term that describes delivering healthcare and healthcare services through telecommunication technology. Although the terms telehealth and mhealth can be used somewhat interchangeably, “telehealth” tends to focus more on leveraging existing technologies – phone, fax and video conferencing to deliver services over a long distance, or to facilitate communication between providers. Remote evaluation and management and robotics are both examples of care innovations that would fall under the telehealth umbrella.

Value-based Purchasing

Value-based purchasing is a reimbursement model for health care providers that rewards outcomes for patients as opposed to the volume of services provided. Both through increased payments for positive outcomes, and decreased payments for negative ones, value-based purchasing seeks to lower costs by focusing on increasing quality and patient-focus. Accountable Care Organizations and Patient Centered Medical Homes are both examples of delivery systems that rely on value-based purchasing.

Medicare News for the Week of February 13, 2012: PQRS, eRX and EHR, EHR and EHR

(PQRS) AM News Reports 2012 Last Year for Physicians to Voluntarily Report Quality Data (jump to story)

(PQRS & eRX) National Provider Call: Claims-Based Reporting for the Physician Quality Reporting System & Electronic Prescribing Incentive Program(jump to story)

(Purchasing) National Provider Call: Hospital Value-Based Purchasing Program (jump to story)

(eRx) Electronic Prescribing (eRx) Incentive Program: Updates for 2012 (jump to story)

(Observation) Some Medicare Beneficiaries Receive Large Bills Over "Observation Care" Status (jump to story)

CMS Gives Consumers Access to More Details about Infection Rates at America's Hospitals – Data Will Save Lives, Cut Costs (jump to story)

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AM News Reports 2012 Last Year for Physicians to Voluntarily Report Quality Data

According to coverage in AM News, "…doctors have only this year to report data to the program voluntarily." …doctors who don't report data will not only not be eligible for a bonus but may be dinged with a 1.5% penalty on their payments in

2015." **Read more in AM News.**

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National Provider Call: Claims-Based Reporting for the Physician Quality Reporting System & Electronic Prescribing Incentive Program – Registration Now Open

Tue Feb 21; 1:30-3pm ET

CMS will host a National Provider Call on the Physician Quality Reporting System & Electronic Prescribing (eRx) Incentive Program. Subject matter experts will provide an overview on claims-based reporting for both programs, followed by a question and answer session.

Target Audience: All Medicare Fee-For-Service Providers, Medical Coders, Physician Office Staff, Provider Billing Staff, Electronic Health Records Staff, and Vendors

Agenda:

- Opening Remarks
- Program Announcements
- Overview of claims-based reporting for the Physician Quality Reporting System
- Overview of claims-based reporting for the eRx Incentive Program
- Question & Answer Session

Registration Information: In order to receive the call-in information, you must register for the call. *Registration will close at 12pm on the day of the call* or when available space has been filled; no exceptions will be made, so please register early. For more details, including instructions on registering for the call, please visit **http://www.eventsvc.com/blhtechnologies**.

Presentation: The presentation for this call will be posted at least one day in advance at **http://www.CMS.gov/PQRS/04_-CMSSponsoredCalls.asp** in the "Downloads" section of the page.

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National Provider Call: Hospital Value-Based Purchasing Program – Registration Now Open

Tue Feb 28; 1:30-3pm ET

The Centers for Medicare & Medicaid Services (CMS) will be creating hospital-specific performance reports that simulate the FY2013 Hospital Value-Based Purchasing Program for each hospital to review; the simulated reports will employ hospital data from prior years to construct each hospital's baseline period and performance period scores. To prepare providers for interpreting the simulated report, this National Provider Call will discuss a sample report that shows what hospitals can expect when they receive their own reports.

Target Audience: Hospitals, Quality Improvement Organizations, medical coders, physician office staff, provider billing staff, health records staff, vendors, and all Medicare Fee-For-Service providers.

Agenda:

- Opening Remarks
- Program Announcements
- Overview of the Hospital Value-Based Purchasing Program
- Presentation and Walkthrough of the Hospital-Specific Report
- Question & Answer Session

Registration Information: In order to receive the call-in information, you must register for the call. *Registration will close at 12pm on the day of the call* or when available space has been filled; no exceptions will be made, so please register early. For more details, including instructions on registering for the call, please visit **http://www.eventsvc.com/blhtechnologies**.

Presentation: The presentation for this call will be posted at least one day in advance at **http://www.CMS.gov/Hospital--Value-Based-Purchasing** in the "Downloads" section of the page.

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Electronic Prescribing (eRx) Incentive Program: Updates for 2012

The Medicare Electronic Prescribing (eRx) Incentive Program, which began January 1, 2009 and is authorized under the Medicare Improvements for Patients and Providers Act (MIPPA) of 2008, provides incentives for eligible professionals who are successful electronic prescribers. A web page dedicated to providing all the latest news on the eRx Incentive Program is available on the Centers for Medicare & Medicaid Services (CMS) website at http://www.cms.gov/ERxIncentive.

Under section 1848(a)(5)(A) of the Social Security Act, for years 2012 through 2014, a Physician Fee Schedule (PFS) payment adjustment applies to eligible professionals who are not successful electronic prescribers at an increasing rate through 2014. Specifically, if the eligible professional is not a successful electronic prescriber for the respective reporting period for the appropriate program year, the PFS amount for covered professional services during the year shall be a percentage less than the PFS amount that would otherwise apply.

The following are key changes for the 2012 eRx Incentive Program:

Group Practice Reporting Option (GPRO) changes

Group practices (who self-nominated and were selected by CMS to participate in the Group Practice Reporting Option) can qualify to earn an eRx incentive if it is determined that the practice is a successful electronic prescriber. This incentive payment is equal to 1.0 percent of the total estimated Medicare Part B PFS allowed charges under the group practice's Taxpayer Identification Number (TIN). The minimum number of times a group must report the eRx measure is 2,500 for large group practices participating in eRx GPRO participants (100 or more individual eligible professionals), 625 for small group practices participating in eRx GPRO (25-99 individual eligible professionals).

Important Changes for the 2013 eRx Payment Adjustment

- Added a second reporting period to avoid the 2013 eRx payment adjustment (6-month reporting period, January 1-June 30, 2012)
- Eligible professionals can report on any billable Medicare Part B PFS service to avoid the 2013 payment adjustment.
- Hardship exemption requests are available for eligible professionals who are unable to report the eRx measure.

Avoiding the 2013 eRx Payment Adjustment

- In order to avoid the 2013 payment adjustment, eligible professionals are now able to report the eRx Quality-Data Code (QDC) on any billable Medicare Part B PFS service. In previous program years, eRx events could only be reported with specified encounter codes. Please note that reporting denominator- eligible events is still required to earn an incentive payment for 2012.
- Additional information on how to avoid future eRx

payment adjustments can be found in the Electronic Prescribing (eRx) Incentive Program – Future Payment Adjustments document located on the CMS eRx website at http://www.cms.gov/ERxIncentive.asp, under the "Educational Resources" section.

2012 Hardship Exemption Requests to Avoid the 2013 Payment Adjustment

- Individual eligible professionals requesting hardship exemptions from the 2013 eRx payment adjustment will be able to submit their request using the CMS Quality Reporting Communication Support Page located at https://www.qualitynet.org/portal/server.pt/community/communications_support_system/234.
- CMS will announce when the Quality Reporting Communication Support Page becomes available for requesting a hardship exemption for the 2013 eRx payment adjustment.
- For more information on the 2012 eRx hardship exemption categories and on the process for requesting an exemption visit the CMS Electronic Prescribing Incentive Program at http://www.cms.gov/ERxIncentive.

Additional Information

- For more information on the 2012 eRx Incentive Program, go to https://www.cms.gov/ERxIncentive/06_E-Prescribing_Measure.asp
- For more information on avoiding future payment adjustments, go to https://www.cms.gov/ERxIncentive/20_Payment_Adjustment_Information.asp

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Some Medicare Beneficiaries Receive Large Bills Over "Observation Care" Status.

CMS, in an effort to reduce spending, requires medical necessity for a patient to be admitted to the hospital. Many times, however, it cannot be determined immediately if patients do require admission to the hospital. In these cases, patients are admitted to observation (today commonly called the CDU, or Clinical Decision Unit) to try to determine if the patient does need to be admitted or can be released. Observation is considered an Outpatient Service (even though the patient is in a hospital bed in the hospital), just as Emergency Room care is considered outpatient service. Patients who have received Observation Care, once they return home and receive a bill, are stunned to find that they are paying according to Medicare Part B. Part B has a deductible plus a 20% co-insurance for all services they received in the hospital as an outpatient. Read more here: **Wall Street Journal**

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CMS Gives Consumers Access to More Details about Infection Rates at America's Hospitals – Data Will Save Lives, Cut Costs

Central line-associated bloodstream infections (CLABSIs) are among the most serious of all healthcare-associated infections, resulting in thousands of deaths each year and nearly $700 million in added costs to the US healthcare system. On Tue Feb 7, CMS announced that *Hospital Compare* will now include data about how often these preventable infections occur in hospital intensive care units across the country. This step will hold hospitals accountable for bringing down these rates, saving thousands of lives and millions of dollars each year.

The Centers for Disease Control and Prevention estimates that in 2009, there were about 41,000 CLABSIs in US hospitals. Studies show that up to 25 percent of patients who get a CLABSI will die from the infection. Caring for a patient with a CLABSI adds about $17,000 to a hospitalization. These infections prolong hospitalizations and can cause death.

Hospital Compare is one of Medicare's most popular web tools. The site receives about 1 million page views each month and is available in English and in Spanish. More information about *Hospital Compare* is online at **http://www.HospitalCompare.-HHS.gov**.

To view the CMS video of Nancy Foster, Vice President of Quality and Patient Safety Policy at the American Hospital Association, discussing *Hospital Compare*, visit the **CMS YouTube channel**.

The full text of this excerpted CMS press release (issued Tue Feb 7) can be found at **http://www.CMS.gov/apps/media/-press/release.asp?Counter=4260**.

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CMS Has Updated the EHR Information Center with New Self-Service Option

Following months of review and collective input, the Electronic Health Record (EHR) Information Center Interactive Voice Response (IVR) system has been enhanced to provide users with an increased number of options and services to make accessing and reviewing data easier than ever before.

For eligible professionals (EPs), eligible hospitals, or critical access hospitals (CAHs), the revised functionality vastly improves the efficiency in obtaining desired information, while also offering a more varied amount of

information and options for callers. CMS is proud to announce that providers can now obtain information through an extensive IVR Self-Service option. Included in this option is a reinforced privacy protection module that requires your individual National Provider Identifier (NPI), the last five digits of your Tax Identification Number (TIN), and your EHR registration ID. Once accepted, this newly enhanced Self-Service tool allows you to:

- Obtain registration status
- Acquire attestation status
- Review payment information
- Check progress towards meeting the $24,000 threshold amount

Users may access these new options by dialing **888-734-6433**, pressing 3 for Self-Service, and entering the authentication elements. These options will be available on the IVR effective Thu Feb 16.

EHR Information Center Hours of Operation: 7:30am-6:30pm CT, Monday through Friday, except federal holidays. (Note that General Information and Self-Service options may be reached via IVR 24 hours a day, except during periods of planned system maintenance or upgrades).

Supplementary information on the program may also be viewed by visiting the **FAQs section of the EHR Incentive Programs website, where users can search for any questions they have about the Medicare or Medicaid EHR Incentive Programs.**

Want more information about the EHR Incentive Programs? Make sure to visit the **EHR Incentive Programs website** for the latest news and updates on the EHR Incentive Programs.

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Updated and New FAQs Added to the CMS EHR Website

CMS wants to help keep you updated with information on the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs, and has recently updated previously-posted FAQs and added new FAQs on several incentive program topics, including reporting periods and incentive payments. Take a minute and review these FAQs:

- For the 2011 payment year, how and when will incentive payments for the Medicare EHR Incentive Programs be made? Read the answer.
- What are the EHR reporting periods for eligible hospitals participating in both the Medicare and the Medicaid EHR Incentive Programs, as well as the requirements for receiving an EHR incentive payment? Read the answer.
- For the Medicare and Medicaid EHR Incentive Programs, how will non-standard (or irregular) cost reporting periods be taken into account in determining the appropriate cost reporting periods to employ during the Medicare and Medicaid EHR Hospital Calculations? Read the answer.
- In order to qualify for payment under the Medicaid EHR Incentive Program for having adopted, implemented, or upgraded to (AIU) certified EHR technology, an eligible professional (EP) working at an Indian Health Services (IHS) clinic may be asked to submit to their State Medicaid Agency an official letter containing information about the clinic's electronic health record from IHS (which is an Operating Division of the United States Department of Health and Human Services). The information in this letter identifies the EHR vendor, the ONC Certified Heath IT Product List (CHPL) number of the EHR, as well as other information regarding the EHR product version and licensure. Does this letter meet states' documentation requirements for AIU? Read the

answer.

- For the Medicaid EHR Incentive Program, how do we determine Medicaid patient volume for procedures that are billed globally, such as obstetrician (OB) visits or some surgeries? Such procedures are billed to Medicaid at a global rate where one global rate might cover several visits. Read the answer.

Want more information about the EHR Incentive Programs? Make sure to visit the **CMS EHR Incentive Programs website** for the latest news and updates on the EHR Incentive Programs.

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Stay Informed via the CMS EHR Incentive Programs Listserv

CMS wants to invite you to join a free email service to receive the latest news on the EHR Incentive Programs. The **CMS EHR Incentive Program listserv** provides timely information on program requirements and changes in the EHR Incentive Programs.

By subscribing to this listserv, you will receive early notification of new program developments, the availability of new resources, and the addition of any new **Frequently Asked Questions** that are published on the CMS EHR Incentive Programs website. **Join** the listserv and visit the **listserv section** of the EHR Incentive Programs website to take a review some of the recent messages we have sent. We encourage you to let others know about the CMS EHR Incentive Program listserv, and to share its messages.

Want more information about the EHR Incentive Programs? Make sure to visit the **EHR Incentive Programs** website for complete information about the CMS Medicare and Medicaid EHR Incentive Programs.

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The 2011 Press Ganey Pulse Report: Medical Practices Must Personalize Their Interactions With Every Patient

Who Is Press Ganey and why are they measuring patient satisfaction?

In 1979, Irwin Press, PhD focused his interest on the modern patient experience, the study of which would lead him to become known as a patient satisfaction expert. In 1984, Dr. Press introduced the importance of survey methodology when establishing a patient satisfaction program and by early 1985, he had developed a survey that would measure patient satisfaction as a means to improve performance. To address the need for statistical analysis and survey methodology, he collaborated with Rod Ganey, PhD and together, the two formed Press Ganey Associates in 1985.

According to their website, today Press Ganey "partners with more than 10,000 health care organizations worldwide to create and sustain high performing organizations, and, ultimately, improve the overall health care experience. Press Ganey works with clients from across the continuum of care – hospitals, medical practices, home care agencies and other providers –

including 50% of all U.S. hospitals."

The Press Ganey Pulse Report is an annual report which collates research and analysis of public and proprietary data and the perspectives of patients, employees and physicians to uncover trends in healthcare. The 2011 report reveals:

"The top priority item for medical practices is sensitivity to patient needs, indicating a need for medical practices to personalize their interactions with every patient."

The remaining top-priority items for medical practices all reference **patient satisfaction with the care provider**, and include:

- Physicians and medical practices need to serve the "whole" patient.
- Physicians and medical practices need to understand a patient's culture, the relationship with a patient's family or caregivers, and the unique communication needs of individual patients.
- Physicians and medical practices need to validate patient concerns and confirm comprehension, which are critical to ensuring compliance with treatment protocols, and also increases the likelihood for better outcomes and greater patient satisfaction.

The report also has some pretty fascinating information on the **Overall Satisfaction in Top 25 Medical Practice Specialties** (!) and **Medical Practice Satisfaction by Waiting Times.** Press Ganey outpatient questions are answered by over 3 million people annually over the course of 12 months. You can download the 2011 Press Ganey Pulse Report **here.**

Press Ganey also has other free resources available on their site:

Improving Health Care Blog

For Medical Practices and Outpatient Facilities – case studies, recorded webinars, ROI resources and White Papers **here**

For Hospitals – case studies, Pulse Reports, Emergency Department resources, recorded webinars, ROI resources and White Papers **here**

For Home Care -case studies, recorded webinars, ROI resources and White Papers **here**

Government Initiatives for Public Reporting – including the Clinician and Group Consumer Assessment of Healthcare Providers and Systems (CGCAHPS) survey, the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey, the Home Health Consumer Assessment of Healthcare Providers and Systems (HHCAHPS) survey, and Meaningful Use and Value-based Purchasing **here**