Partnership for Prevention
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Multi-State Collaborative for Health Systems Change
Supporting Health Care to Reduce Tobacco Use

Action TO QUIT
Advancing Tobacco Control Policy

Meaningful Use, Tobacco Cessation, and State Tobacco Control Programs
Frequently Asked Questions (FAQs)

Q1: What is Meaningful Use?
A: Meaningful Use is an incentive program that allows eligible providers and hospitals to earn incentive payments by meeting specific electronic health record criteria and standards that are set by the Centers for Medicare & Medicaid Services (CMS). Separate incentive programs exist for Medicare and for Medicaid. The Medicare program is administered by CMS. The Medicaid program is administered by states.

The goal of Meaningful Use is to accelerate the adoption of electronic health records by providers in order to improve health care in the United States. Increased and improved use of electronic health records has the potential to provide clinicians with greater access to information needed to diagnose health problems and improve outcomes, and can empower patients to take a more active role in their health.

The Meaningful Use incentive program was established as a result of the Health Information Technology for Economic and Clinical Health (HITECH) Act, which provided the Department of Health & Human Services (HHS) with the authority to establish programs to improve health care quality, safety, and efficiency through the promotion of health information technology.

Q2: Why is Meaningful Use important to my state's tobacco cessation efforts?
A: There are several reasons why addressing Meaningful Use is critically important to your state's tobacco cessation efforts:

(1) **If strong tobacco dependence screening and treatment standards are not a part of each stage of Meaningful Use, health care systems may not fully integrate them into their new electronic health record systems:** New electronic health record templates will be largely driven by the criteria and standards that CMS sets for meeting the Meaningful Use incentive. While Stage 1 included screening and treatment of tobacco use as a required measure, Stage 2 tobacco interventions are now strongly recommended, but optional. There is no guarantee that future stages will continue to maintain tobacco treatment as a standard. See responses to Q3 for suggestions on how your state Tobacco Control Program can encourage inclusion of tobacco-related measures in subsequent stages.

(2) **The design of electronic health record templates for tobacco dependence screening and treatment will drive how it is addressed:** As hospitals and clinics switch from paper records to electronic-based systems, we have an opportunity to make sure that tobacco dependence screening and treatment not only remain a part of the health record system, but are designed in

ways that yield routine, consistent practice. Electronic health record templates, which are electronic tools for organizing, presenting, and capturing clinical data, can be designed to promote routine screening and treatment for tobacco dependence. If public health and tobacco prevention and control experts are not engaged in helping hospitals and clinics to design effective templates, tobacco screening and treatment may be delivered inconsistently, or may not follow best practice recommendations.

(3) **Electronic health records are only one piece of the system:** While not directly related to the Meaningful Use incentive, Meaningful Use provides an opportunity for public health professionals and tobacco control experts to work with participating hospitals and clinics to drive the design and development of changes in health systems (per the Public Health Service Guidelines) in directions that reinforce routine tobacco use screening and treatment.

Q3: What can my state Tobacco Control Program do about Meaningful Use and Tobacco Cessation?
A: Addressing Meaningful Use should be a key part of your state's efforts related to health systems change. There are a few specific areas where your Tobacco Control Program can play an important role:

(1) **Encourage Comment on Meaningful Use Rules:**
In advance of each stage of Meaningful Use, CMS releases a "rulemaking" document for public comment. Public comments help determine which standards will remain a part of the Meaningful Use incentive, and what data clinicians and hospitals have to collect to meet the incentive criteria. Since there is no guarantee that tobacco use screening and treatment measures will remain a mandatory part of the incentive criteria, it is critical that states work with their clinician partners (health systems, professional organizations, champion clinicians, etc.) to encourage comment on the rulemaking. In particular, comments might focus on: (a) supporting the continued mandatory inclusion of tobacco-related measures, and (b) describing examples of effective implementation of tobacco cessation measures in the electronic health record which illustrate that this is feasible, is not burdensome, and yields rapid benefits. A number of national organizations, including Partnership for Prevention and the Multi-State Collaborative, will work to alert states to the comment periods as they occur.

(2) **Partner with participating clinicians, health systems, and hospitals to help them implement electronic health record systems and Meaningful Use in alignment with the Public Health Service Guideline** While having an effective tobacco dependence screening and treatment template is critical to a comprehensive tobacco treatment system, it is not sufficient. Comprehensive tobacco treatment systems depend on the delivery of effective brief cessation interventions (e.g., 5A or 2AR) and the availability and utilization of community-based and statewide cessation resources. Utilizing Meaningful Use as an opportunity to promote other important aspects of health systems change can maximize tobacco cessation efforts.

(3) **Leverage data from electronic health records for surveillance/evaluation:** Encounter level data from electronic health records is where the nuts and bolts of Meaningful Use resides. Beyond the incentive phase, one major long-term goal of Meaningful Use is to improve health outcomes. Studies have already shown that clinical encounter records can be used to demonstrate reductions

in smoking prevalence and improved health outcomes for tobacco related illnesses. This type of work could lead to the creation of new Meaningful Use measures for later Stages in the Meaningful Use process. As part of this ongoing effort, Tobacco Control Programs can work with healthcare providers, provider groups, insurers, schools of public health, and other university researchers to obtain access to electronic health records and help build the case for health improvements that relate directly to Meaningful Use measures.

Additional Details about Meaningful Use

Q: Who can participate in the Meaningful Use Incentive Program?
A: Eligible providers are those recognized by Medicare and Medicaid and include Doctors of Medicine or Osteopathy, Doctors of Dental Surgery or Dental Medicine, Doctors of Podiatric Medicine, Doctors of Optometry, and Chiropractors. Eligible hospitals are those recognized by Medicare or Medicaid, including critical access hospitals. Providers and hospitals must choose to participate in either the Medicare incentive program or the Medicaid incentive program (i.e., they cannot choose both).

Q: How much can Meaningful Use participants earn in incentives?
A: The maximum incentive for eligible providers under Medicare is $44,000 over a five-year period. The maximum incentive for eligible providers under Medicaid is $63,750 over a six–year period. Hospitals can receive up to $2 to $6 million over the same time period. A 10% bonus is available under Medicare for providers that participate from Health Professional Shortage Areas (HPSAs). Maximum incentives are earned by enrolling early and meeting criteria at each stage. Payment reductions will occur for hospitals that do not demonstrate meaningful use by 2015.

Q: How long is the Meaningful Use Incentive Program?
A: Meaningful Use has three stages. The first stage (2011-2012) focuses on capturing and sharing data in the electronic health record. The second stage (2014) focuses on advancing clinical processes. The third stage (2016) focuses on improving health care quality and outcomes. Participating clinicians and hospitals can receive incentives throughout the various stages, based on meeting different criteria outlined as part of each stage. For Medicare, clinicians and hospitals not registered for the Incentive Program after 2014 will not be able to participate; the last year to receive an incentive payment from the Medicare program is 2016. For Medicaid, participants must register by 2016, and the last year to receive incentive payment is 2021.