

Health Information Technology and Meaningful Use at the Federal and State Level

Nebraska Rural Health Association

Annual Conference

September 22, 2011



NEBRASKA RURAL HEALTH ASSOCIATION

Session Presenters

- Marty Fattig,
 - CEO ,Nemaha County Hospital
- John Gorman, MS, PMP
 - Program Manager, Wide River TEC
- Kevin Conway
 - VP, Health Information, Nebraska Hospital Association



NEBRASKA RURAL HEALTH ASSOCIATION

HIT and Meaningful Use at the Federal and State Level

Marty Fattig

Nebraska Rural Health Conference

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MU Stage 2 Recommendations

- Timeline
 - Jan 2011- Feb 25,2011- Draft –Public Comments
 - April/May 2011- MU WG revises Draft
 - June 8, 2011- MU WG Final Stage 2 recommendations to HITPC
 - ~Aug/Sept 2011- ONC submission to CMS
 - ~Jan 2012 CMS issue NPRM Stage 2
 - ~June 2012- Final Rule
 - ~Oct 1, 2012- MU Hospital Fiscal Year
 - ~Jan 1, 2013- MU Eligible Provider

Workgroup Membership

Co-Chairs:

Paul Tang
George Hripcsak

Palo Alto Medical Foundation
Columbia University

Members:

- David Bates
Brigham & Women's Hospital
- Michael Barr
American College of Physicians
- Christine Bechtel
National Partnership/Women & Families
- Neil Calman
Institute for Family Health
- Art Davidson
Denver Public Health
- Marty Fattig
Nemaha County Hospital
- James Figge
NY State Dept. of Health
- Joe Francis
Veterans Administration
- David Lansky
Pacific Business Group/Health
- Deven McGraw
Center/Democracy & Technology
- Judy Murphy
Aurora Health Care
- Latanya Sweeney
Carnegie Mellon University
- Karen Trudel
CMS
- Charlene Underwood
Siemens

Reminder of Stage 2 Timing Issue

Timing of EHR Certification and MU Stage Objectives

Considered:

1. Maintain current timeline and one-year EHR reporting period; or
2. Maintain current timeline and permit 90-day EHR reporting period; or
3. Delay transition from stage 1 to stage 2 by one year only for providers who qualify for MU in 2011

Recommends #3

TABLE 1—STAGE OF MEANINGFUL USE CRITERIA BY PAYMENT YEAR

First Payment Year	Payment Year			
	2011	2012	2013	2014
2011	Stage 1	Stage 1	Stage 2	Stage 2.
2012 .....	.....	Stage 1	Stage 1	Stage 2.
2013 .....	.....	.....	Stage 1	Stage 1.
2014 .....	.....	.....	.....	Stage 1.
	Complete EHRs and EHR Modules certified by ONC-ATCBs or ONC-ACBs ² to all of the applicable certification criteria adopted for the 2011 & 2012 payment years meet the definition of Certified EHR Technology.		Complete EHRs and EHR Modules certified by ONC-ACBs to all of the applicable certification criteria adopted for the 2013 & 2014 payment years meet the definition of Certified EHR Technology.	

Draft Stage 2 MU Objectives

Improving Quality, Safety, Efficiency & Reducing Disparities

Stage 1 Final Rule	HITPC Proposed Stage 2
Improving Quality, Safety, Efficiency & Reducing Health Disparities	
<p>>30% of unique patients with at least one med order have at least one med order entered using CPOE</p>	<p>Raise threshold to >60% for medication orders and include at least one lab order using CPOE for >60% of unique patients who have at least one lab test result; at least one radiology test is ordered using CPOE (unless no radiology orders)</p>
<p>Implement drug-drug and drug-allergy interaction checks (enabled functionality)</p>	<p>Employ drug interaction (drug-drug, drug-allergy) checking; Providers have the ability to refine DDI rules. [In stage 3, goal is to have nationally endorsed lists of DDI with higher positive predictive value and ability to record reason for overriding alert]</p>
<p>EP: Generate and transmit permissible prescriptions electronically for >40% of prescriptions</p>	<p>50% of outpatient medication orders and 10% of hospital discharge medication orders transmitted as eRx</p>
<p>>50% of all unique patients have demographics recorded as structured data. (preferred language, gender race ethnicity, DOB, date and preliminary COD- EH ONLY).</p>	<p>80% of patients have demographics recorded and can use them to produce stratified quality reports; for stage 3, use more granular demographic categories per IOM report (HITSC needs to work on standards for granular demographics)</p>
<p>Report CQM as per CMS attestation</p>	<p>Report CQM electronically as per CMS</p>
<p>Maintain an up-to-date problem list for >80% of all unique patients</p>	<p>Maintain problem list <u>(80%)</u></p>

Draft Stage 2 MU Objectives

Improving Quality, Safety, Efficiency & Reducing Disparities, II

Stage 1 Final Rule	HITPC Proposed Stage 2
Maintain active med list for >80% of all unique patients	Maintain active med list <u>(80%)</u>
Maintain active med allergy list for >80% of all unique patients	Maintain active med-allergy list <u>(80%)</u>
Record and chart vital signs for >50% of all unique patients age 2 and over	80% of patients have vital signs recorded during the reporting year; change age for peds BP from 2 yrs to 3 yrs
Record smoking status for >50% of all unique patients 13 years or older	80% of patients have smoking status recorded [stage 3 add new field in certification for secondhand smoke]
Implement 1 clinical decision support rule relevant to specialty or high clinical priority along with ability to track compliance	Use CDS; HITSC: Suggest changing certification criteria definition as indicated on comment summary
Menu: Implement drug-formulary checks with access to at least one drug formulary	Move to Core: Implement drug formulary checks according to local needs (e.g., may use internal or external formularies, which may include generic substitution as a “formulary check”)
Menu: Record AD for 50% of all unique patients 65 years and older	Move to Core: For hospitals (inpatient), 50% of patients 65 years and older have recorded whether an advance directive exists (with date and timestamp of recording) and access to a copy of the directive itself if it exists; for EPs, >25 unique patients have recorded whether an advance directive exists (with date and timestamp of recording) and access to a copy of the directive itself if it; (signal ability to store and retrieve AD for Stage 3)

Draft Stage 2 MU Objectives

Improving Quality, Safety, Efficiency & Reducing Disparities

Stage 1 Final Rule	HITPC Proposed Stage 2
<p>Menu: Incorporate clinical lab-tests results as structured data for more than 40% of all lab tests results ordered</p>	<p>Move to Core: Incorporate lab results as structured data (40%); HITSC: Use LOINC where available</p>
<p>New</p>	<p>EHs: Hospital labs <i>send</i> (directly or indirectly) structured electronic clinical lab results to outpatient providers for ≥ 40% of electronic orders received; HITSC: Use LOINC where available; (note challenge to small hospitals; may require exclusions)</p>
<p>Menu: Generate at least one report listing patients by specific conditions</p>	<p>Move to Core: Generate patient lists for multiple patient-specific parameters</p>
<p>Menu: Send an appropriate reminder for preventive/follow up care to more than 20% of all unique patients 65 years or older or 5 years or younger</p>	<p>Move to Core: EPs:10% of all active patients are sent a clinical reminder (reminder for existing appointment does not count)</p>
<p>New</p>	<p>30% of EP visits have at least one electronic EP note and 30% of EH patient days have at least one electronic note by a physician, NP, or PA; non-searchable, scanned notes do not qualify [use broad definition of qualifying note types]</p>
<p>New</p>	<p>EH medication orders automatically tracked via electronic medication administration record; (in-use in at least one hospital ward/unit) (“automatically” implies “5 rights” recorded without manual transcription)</p>
<p>New</p>	<p>Consider adding recording of family health history in stage 3 (due to absence of standards for FH)</p>

Draft Stage 2 MU Objectives

Engaging Patients and Families

Stage 1 Final Rule	HITPC Proposed Stage 2
Provide >50% patients with an electronic copy of health information	(combined with other objectives)
EH: Provide >50% of all discharged patients with an electronic copy of their discharge instructions	(discharge instructions combined with other objectives)
New	Hospitals: 10% of patients/families view and have ability to download [took out “relevant”] information about a hospital admission; information available for all patients within 36 hours of the encounter
Menu: Provide >10% of all unique patients with timely electronic access to health information (EP)	Move to Core: EPs: >10% of patients/families view & have ability to download their longitudinal health information; information available to all patients within 24 hours of an encounter (or within 4 days after available to EPs) [P&S TT to consider whether a P&S warning should be put in S&C criteria]
Provide Clinical Summaries to patients for >50% of all office visits within 3 business days	EPs: patients are provided a clinical summary after 50% of all visits, within 24 hours (pending information, such as lab results, should be available to patients within 4 days of becoming available to EPs; (electronically accessible for viewing counts)
Menu: Use certified EHR technology to identify patient-specific educational resources and provide to patient if appropriate for >10% of all unique pts.	Move to Core: Both EPs and hospitals: 10% of patients are provided with EHR-enabled patient-specific educational resources; make core; take out “if appropriate” instead of raising threshold
New	EPs: patients are offered secure messaging online and at least 25 patients have sent secure messages online
New	EPs: Patient preferences for communication medium recorded for 20% of patients
New	Stage 3: Provide mechanism for patient-entered data (supply list); consider “information reconciliation” for stage 3 to correct errors

Draft Stage 2 MU Objectives

Improve Care Coordination

Stage 1 Final Rule	HITPC Proposed Stage 2
Improve Care Coordination	
Capability to exchange key clinical information – Perform at least one test	(HIE test eliminated in favor of use case objectives)
Menu: Perform medication reconciliation for >50% of transitions for receiving provider	Move to Core: Medication reconciliation conducted at >50% of transitions by receiving provider
Menu: Provide summary of care record for >50% transitions of care for the referring EP or EH	<p>EH and EP: Record and provide (by paper or electronically) a summary of care record for >50% transitions of care for the referring EP or EH</p> <p>EH and EP: Record care plan fields (goals and instructions in Stage 2) for 10% of patients [majority voted in favor, minority wanted 50% threshold]</p> <p>EH and EP: Record team member (including PCP, if available; unstructured in Stage 2) for 10% of patients</p> <p>EH: 10% of all discharges have care summary (including care plan and care team if available) sent electronically to EP or post-acute care facility. EP: at least 25 transactions sent electronically.</p>
New	(care team merged with summary of care)
New	(care plan objective merged with summary of care)

Draft Stage 2 MU Objectives

Improving Population and Public Health

Stage 1 Final Rule	HITPC Proposed Stage 2
Improve Population and Public Health*	
Capability to submit electronic data to immunization registries or immunization IS – Perform a test	EH and EP: Submit immunization data (attest to at least one) in accordance with applicable law and practice; move to core for both EH and EP [In Stage 3, view cumulative immunization record and recommendations]
EH: Capability to submit electronic lab data on reportable lab results to public health agencies – Perform a test	EH: Submit reportable lab results (attest to submitting to at least one organization) in accordance with applicable law and practice; move to core
Capability to submit electronic syndromic surveillance data to public health agencies - Perform a test	EH: Submit syndromic surveillance data (attest to at least one) in accordance with applicable law and practice; move to core
New for Stage 3	For Stage 3: Patient-generated data submitted to public health agencies
*Signal to HITSC to include a single standard to be used for submitting PH data for each PH objective.	

Draft Stage 2 MU Objectives

Ensure Privacy and Security Protections

Stage 1 Final Rule

HITPC Proposed Stage 2

Ensure adequate privacy and security protections for personal health information

Conduct or review a security risk analysis and implement security updates as necessary and correct identified security deficiencies as part of the its risk management process

Perform, or update, security risk assessment and address deficiencies

Address encryption of data at rest

Signal that Stage 3 may require meeting conditions of participation in NWHIN

Stage 2

- Nothing in statutes about how beginning or ending of stages.
- Needs to be progressive
- Be aware of penalties for not being a meaningful user.
- Much to be decided before NPRM

Contact Information

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The Challenges and Opportunities of Meaningful Use

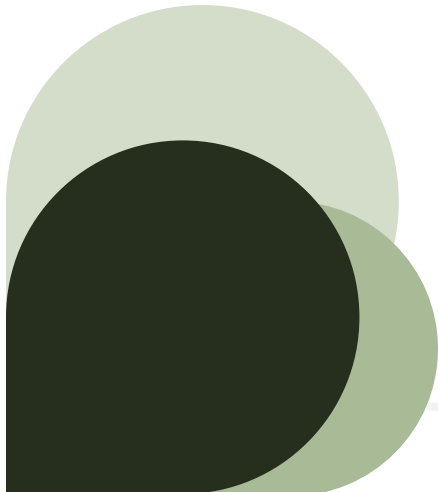
September 22, 2011



Awardee of The Office of the National Coordinator for Health Information Technology

John Gorman, MS, PMP
Program Manager, Wide River TEC

This document was developed by CIMRO of Nebraska through funding from the United States Office of the National Coordinator, Department of Health and Human Services, grant number 90RC0018/01. Form No. 0168-0811





EHR Adoption: Priority Primary Care Provider (PPCP) Clinic Challenges

- Vendor certification and/or upgrades
 - Some vendors have yet to certify their EHR products
 - Certified versions are continually being upgraded
- Additional charges for certified versions
 - Some vendors are charging significant fees for upgrade
 - A contract review and/or dispute costs time and money



EHR Adoption: PPCP Clinic Challenges

- Support Costs
 - Consider your worst case scenario and choose vendors accordingly
 - Get legal review of all contracts to ensure your expectations are met
- Staff Shortages
 - Who works on the EHR and when?
 - Who is responsible for ensuring Meaningful Use is being met?
- Security Audit
 - Lack of clarity and fear of audit



EHR Adoption: PPCP Clinic Opportunities

- Meaningful Use → Meaningful Outcomes = Mission
 - Requirements align with quality care
- Retain and Recruit New Physicians
 - Many clients have cited the EHR as essential to meet this goal
- Celebrate the Tangible and Intangible Benefits
 - Flexibility to review records from home
 - Deciphering illegible charts or searching for lost charts is gone



EHR Adoption: PPCP Clinic Opportunities

- Disaster Recovery and Business Continuity
 - Katrina; Joplin MO; Theft; Joining a new practice
 - Hard to practice paper based medicine when paper is gone
- Opportunity to Put the “I” in Health IT
 - Don’t forget about the patient
 - Showcase your project to your Community



EHR Adoption

Critical Access Hospital Challenges

- Competing Priorities
 - Facility Updates
 - ICD-10
 - Impact of Health Reform
- Existing Technology
 - Choose same vendor that you use for Billing/Reg?
 - Rip and Replace ROI?
- Timeline Challenges
 - Medicare Reimbursement Formula vs. Fiscal Year
 - Vendor Availability
- Staffing and End User Buy-in



EHR Adoption

Critical Access Hospital Opportunities

- Meaningful Use → Meaningful Outcomes = Mission
 - Requirements align with quality care
- CAH Medicare Reimbursement
 - Include hardware and interfaces
- Put the “I” in Health IT
 - Don’t forget about the patient
 - Showcase your project to your community
- Quality and Process Improvement
 - Don’t pave the cow path

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NHA Nebraska
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Medicaid Incentives

- SMHP submitted June 24, 2011
 - CMS requesting “clarifications”
- Anticipated approval in October
- Attestation and payment starting in November

Medicaid Patient Volume –EH/EP

- AIU – Adoption, Implementation or Upgrade year 1
 - Full Meaningful Use year 2
- Includes FFS and Managed Care
 - Excludes CHIP
- Continuous 90 day period
- Medicaid paid claim or premium

Eligible Hospital Patient Volume

- Acute or CAH
 - 10% patient encounters
 - Includes inpatient discharges and “daily” ER encounters
- Children’s Hospitals
- *Must be recalculated each year of payment*

Eligible Physician Patient Volume

- Physician, dentist, nurse-midwife, nurse practitioner
 - 30% patient encounters
 - Pediatricians must have 20%
- Or physician assistance predominantly in FCHC or RHC over 6 months
- Provider is not hospital based
 - 90% not inpatient “21” or ER “23”

Hospital Payment Calculation

- Medicare Share
 - Inpatient Acute Discharge Days
 - Excludes NB
- Calculated once for 4 year payment
- Transition Factors: 1 -.75 - .50 .25
- Paid over 3 years
 - 50% - 40% - 10%

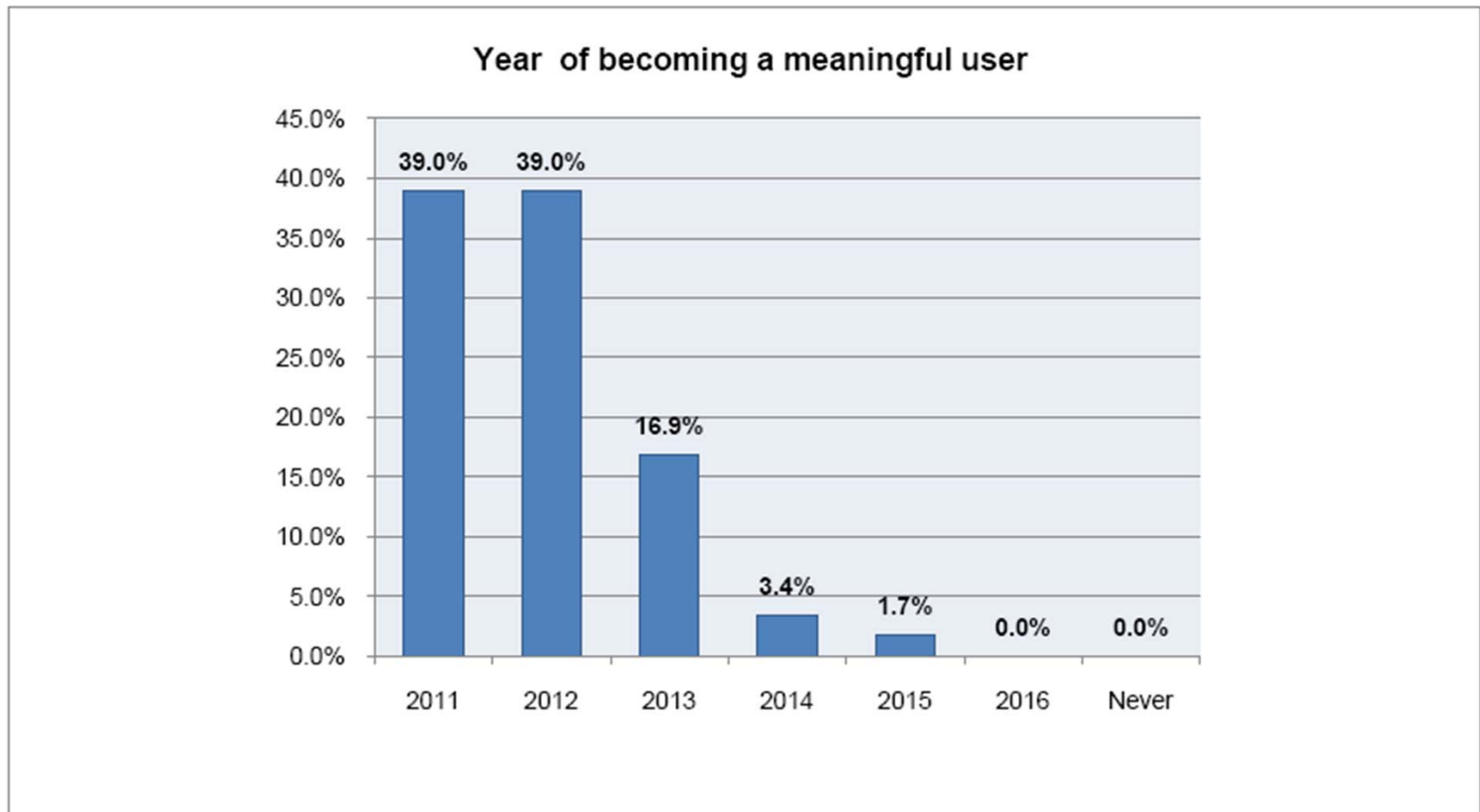
Hospital Time Table

- Benefits now or lose them later
 - Medicare PPS Hospital Incentives

Year of Adoption	2011	2012	2013	2014	2015	2016	2017
Payment for adopting in FY 2011	100%	75%	50%	25%			
If first adopting in FY 2012:		100%	75%	50%	25%		
If first adopting in FY 2013:			100%	75%	50%	25%	
If first adopting in FY 2014:				75%	50%	25%	
If first adopting in FY 2015:					50%	25%	
Penalties begin if not adopting by FY 2015: Three-quarters of the applicable market basket update is reduced by:					33.33%	66.66%	100%

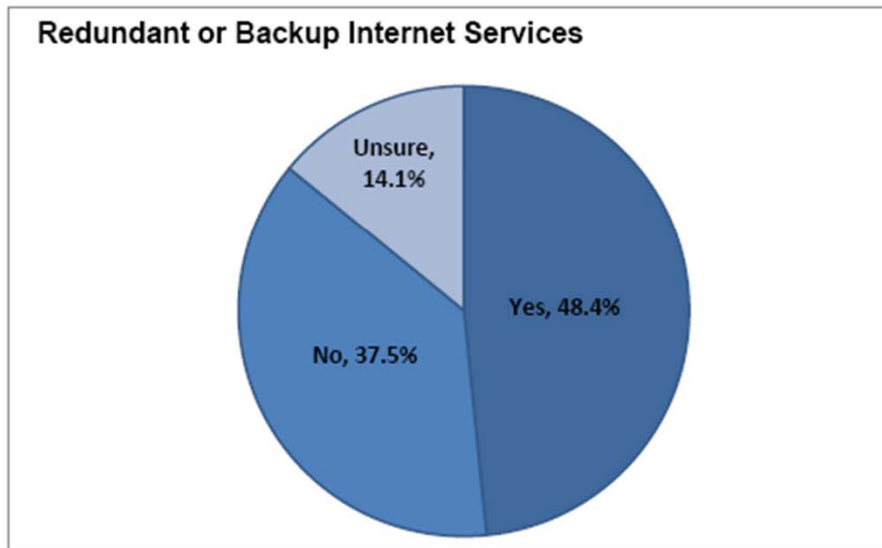
SMHP Survey

What year does the hospital plan to become a Meaningful User of EHR technology? (q28)



SMHP Survey

Does the hospital have redundant or back-up internet services? (q20)



Answer Options	Response Percent	Response Count
Yes	48.4%	31
No	37.5%	24
Unsure	14.1%	9
answered question		64
Skipped questions		5



Active Registrations - August 2011

		August-11	YTD
Medicare Meaningful Use (MU)	Eligible Professional	9,268	71,378
	Hospital	0	121
	Total	9,268	71,499
Medicaid Adopt, Implement or Upgrade (AIU)	Eligible Professional	3,569	17,181
	Hospital	3	37
	Total	3,572	17,218
Medicare/Medicaid	Hospital (registered for both Medicare & Medicaid)	259	1,933
TOTAL		13,099	90,650



Medicare Incentive Payments – August 2011 Meaningful Use (MU)

	August 2011 Providers Paid	August 2011 Payments	YTD Providers Paid	YTD Payments
Eligible Professional	1,051	\$18,918,000	2,129	\$ 37,350,000
Hospital	0	\$0	4	\$ 5,069,516
Medicare & Medicaid Hospital (Medicare Payment)	48	\$95,942,938	110	\$ 220,822,305
TOTAL	1,099	\$114,860,938	2,243	\$ 264,212,821

Questions?

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