

Understanding the Meaning of Meaningful Use



**Key
Health
Alliance**

Regional Extension
Assistance Center for HIT

Paul Kleeberg, MD, FAAFP, FHIMSS
Clinical Director

Regional Extension Assistance Center for HIT (REACH)

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Conflict of Interest

- Dr. Kleeberg has recently taken the position of Clinical Director for the Minnesota – North Dakota Regional HIT Extension Center, REACH. He will be mentioning it in this talk.
- No other conflict of interest

Objectives

- Understand the drivers behind this push to implement health information technology (HIT)
- Understand how the incentive program fits into the broader range of programs intended to facilitate adoption of HIT
- Understand the definition of an eligible provider and eligible hospital and the calculation of incentives
- Be able to identify the national health care goals underlying meaningful use framework
- Understand what you can do to be eligible for incentives and avoid penalties
- Understand how to leverage your HIT Extension Center

Outline

- The Drivers
- The Recovery Act
- Financial Incentives for Hospitals and Providers
- Proposed Elements of Meaningful Use
- Proposed Quality Measures
- What You Can Do
 - Regional Extension Centers for HIT

National Academies Reports

- *To Err is Human: Building a Safer Health System (1999)*
 - Identified that at least 44,000 and perhaps as many as 98,000 hospitalized Americans die every year from medical errors
- *Crossing the Quality Chasm (2001)*
 - A concerted national commitment to building information infrastructure is needed to support health care delivery
- *Preventing Medication Errors (2007)*
 - Medication errors injure 1.5M people and cost \$3058 per year (exclusive of lost wages and productivity) in the U.S.
- *Computational Technology for Effective Health Care: Immediate Steps and Strategic Directions (2009)*
 - “Crossing the Health Care IT Chasm:” Even in organizations with advanced HIT, it is rarely used to provide clinicians with evidence-based decision support or for data-driven process improvement

U.S. Healthcare Problems

- Highest per capita health care spending
- Ranked 37th of 191 in quality*
- Threatens affordable care
 - 46 million currently uninsured
 - 71% of uninsured adults are employed full-time
- \$2T (2005) → \$4T (2015)
 - Increasing % of GDP

Patients Want More Accessible, Coordinated, Well-Informed Care

Percent reporting it is very important/important that:	Total:		
	Very important or important	Very important	Important
You have easy access to your own medical records	94	68	27
All your doctors have easy access to your medical records	96	72	24
You have information about the quality of care provided by different doctors/hospitals	95	63	32

National Health Care Goals and Meaningful Use of Health IT

Why Health IT?

“...HIT has the potential to improve health care quality, prevent medical errors, increase the efficiency of care provision and reduce unnecessary health care costs, increase administrative efficiencies, decrease paperwork, expand access to affordable care, and improve population health.”

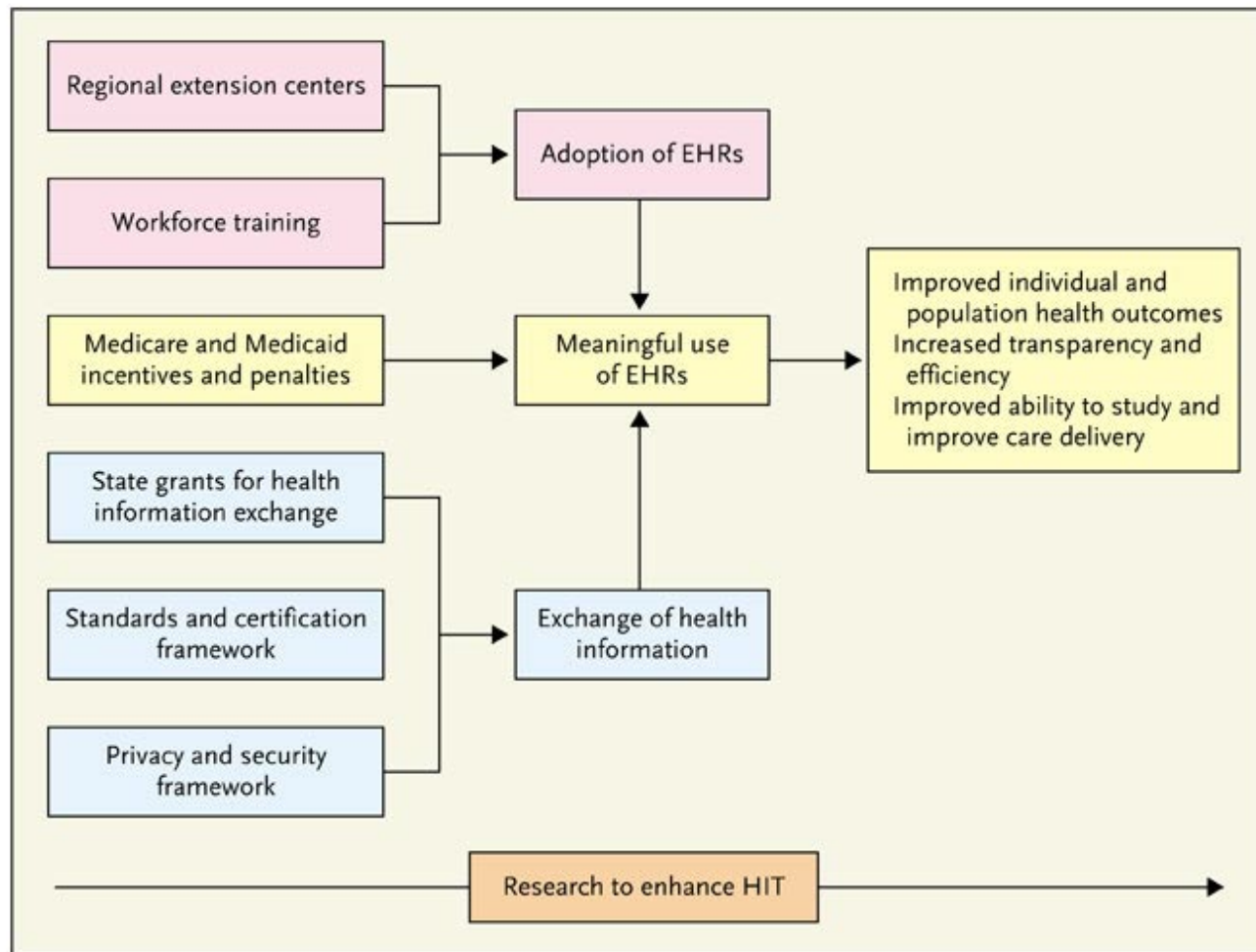
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Placing our Bet on HIT: The “Stimulus Package”

- The stimulus package (Feb 2009)
 - American Recovery and Reinvestment Act (ARRA) - \$787 B
 - Health Information Technology for Economic and Clinical Health (HITECH) Act
 - \$29.2 B (\$17.2 B net) starting in 2011 to incent Medicare- and Medicaid-participating physicians and hospitals to use certified EHR systems in a “meaningful” way

The HITECH Act's Framework



Part of a Broader Agenda

Funding Initiative	Focus
CMS Incentives (Section 4201) For “meaningful use”	Incentive payments to eligible professionals and hospitals participating in Medicare and Medicaid programs that adopt and meaningfully use certified EHRs.
Regional Extension Centers (Section 3012)	Establish up to 70 Regional Extension Centers to support providers in adopting and becoming meaningful users of health information technology (HIT)
Health Information Exchange (Section 3013)	Support state programs to ensure the development of health information exchange
HIT Workforce Development (Section 3016) University-based Training; Community College Consortia; Curriculum Development; Competency development	Create several distinct programs that aim to support the education of HIT professionals . The goal is to train up to 45,000 new HIT workers to assist providers in becoming meaningful users of EHRs
Beacon Community Program (Section 3011)	Create up to 15 demonstration communities to show how the meaningful use of EHRs can achieve measurable improvement in the quality and outcomes
Strategic Health information technology Advanced Research Projects (SHARP) - (Section 3011)	Achieving breakthroughs to address well-documented problems that have impeded adoption of HIT, including: the security, cognitive support, health care application & network architectures, & secondary use of EHR data

Meaningful Use Overview: Statutory Framework

In HITECH, Congress established three fundamental criteria of requirements for meaningful use:

1. Use of certified EHR technology in a meaningful manner
2. Certified EHR technology is connected in a manner that provides for the electronic exchange of health information to improve the quality and coordination of care
3. In using certified EHR technology, the provider submits clinical quality measures and other measures as determined by the secretary

CMS and ONC Proposed / Interim Rules:

CMS Notice of Proposed Rule Making (NPRM) for EHR Incentive Program

Defines the provisions for incentive payments to eligible professionals and hospitals participating in Medicare and Medicaid programs that adopt and meaningfully use certified EHRs.

Public Comment Period closed

Final Rule to be released late June, takes effective 60 days later

ONC Interim Final Rule (IFR) on Standards and Certification Criteria

Proposes initial set of standards, implementation specifications, and certification criteria to “enhance the interoperability, functionality, utility, and security of health IT and to support its meaningful use.”

Effective Date: February 13, 2010

Public Comment Period closed

Final Rule to be released June 2010, takes effective 30 days later

ONC Notice of Proposed Rule Making (NPRM) for EHR Certification

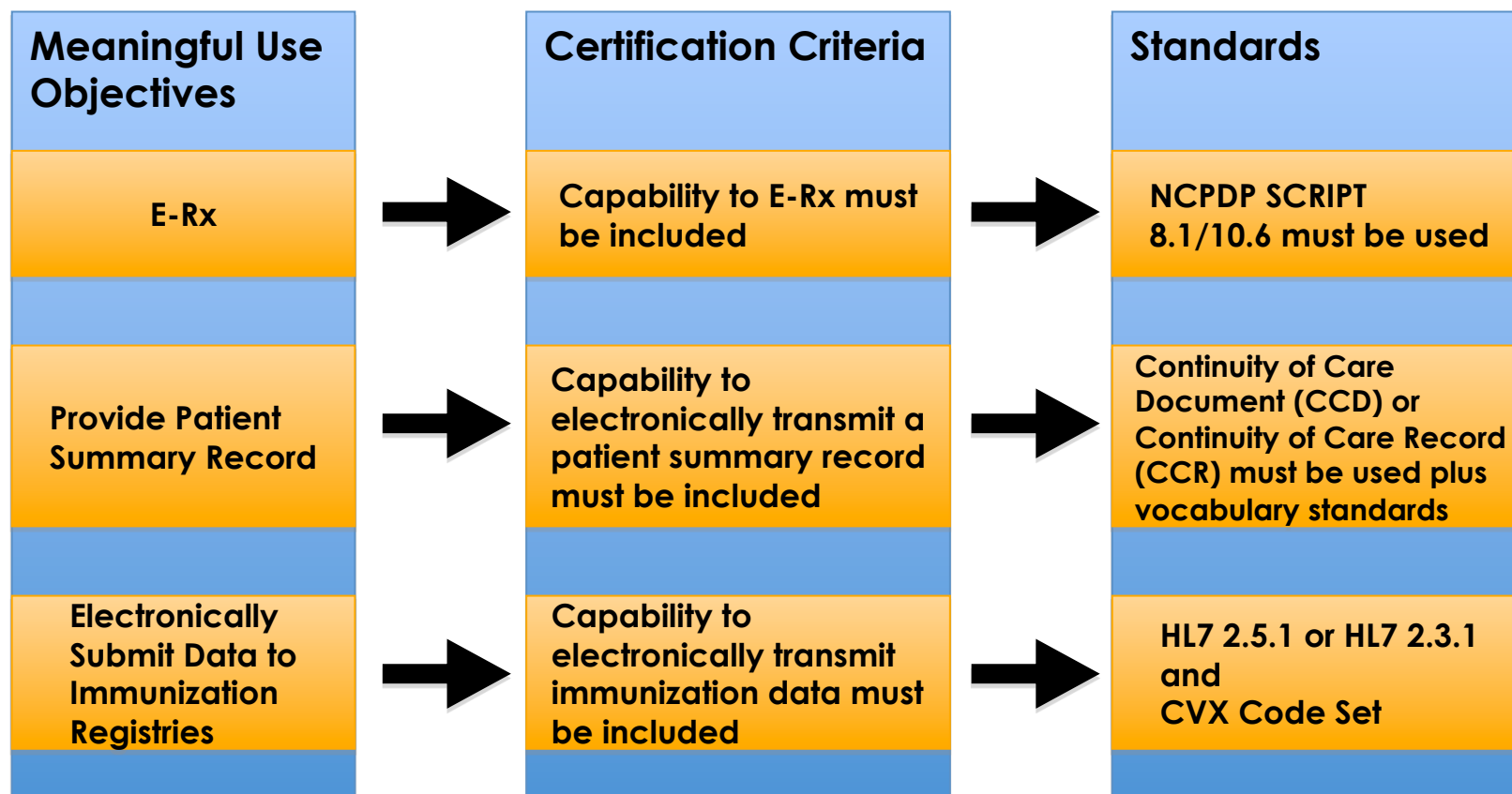
Addresses the process by which EHR systems will be certified and by which accreditation/certification entities can become recognized by CMS in order to certify EHR systems.

Public Comments closed

Transitional criteria to be released late June 2010

Final Rule to be released early fall 2010

Aligning Certification and Standards



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Incentive Program Overview

The Notice of Proposed Rule Making (NPRM) specified...

- Eligibility requirements for professionals and hospitals
- Criteria for Stage 1 Meaningful Use
- Reporting methodology and timeframes
- Payment periods
- Payment calculations/procedures for Medicare & Medicaid
- Medicare penalties for failing to meaningfully use certified EHRs
- Medicaid Agencies' implementation of incentives

Incentive Program Key Provisions

Eligibility

- Eligible Hospitals can receive both Medicare and Medicaid incentives
- Eligible Critical Access hospitals are only eligible for Medicare Incentives
- Eligible professionals must choose between Medicare & Medicaid Incentives, but may switch once

“Stage 1” Criteria for Being Deemed a Meaningful User of Certified EHR

- 25 objectives and measures for eligible professionals (EP)
- 23 objectives and measures for eligible hospitals (EH)
- Criteria for “Stage 2” & “Stage 3” to be defined through future rulemaking
- EPs and EHs must meet all of the criteria.

Reporting Mechanisms

- Of the 25 EP objectives, 7 require attestation; 18 require data submission
- Of the 23 EH objectives, 8 require attestation; 15 require data submission
- In 2012, CMS expects eligible professionals and hospitals to report clinical quality metrics electronically

Incentive Program Key Provisions (contd.)

Timeframe for Demonstrating Meaningful Use (MU):

- In the 1st payment year, hospitals must demonstrate MU over any continuous 90 period in a fiscal year; for subsequent payment years hospitals must demonstrate MU over the entire fiscal year.
- In the 1st payment year, professionals must demonstrate MU over any continuous 90 period in a calendar year; for subsequent payment years professionals must demonstrate MU over the entire calendar year.

Medicare and Medicaid

- The proposed rule lays out how the Medicare program will operate.
- The proposed rule will serve as the base for Medicaid, but states have leeway to build upon the federal MU definition
- States are currently in the process of receiving federal funds to develop their own EHR incentive programs for Medicaid

Definition of a Medicare Eligible Provider

- A physician, defined by the Social Security Act Sec 1861 (r):
 - A doctor of medicine or osteopathy
 - A doctor of dental surgery or dental medicine
 - A doctor of podiatric medicine
 - A doctor of optometry
 - A chiropractor
- Does not provide more than 90% of services with a place of service (POS) code of 21, 22 or 23 (considered hospital inpatient or outpatient based)
- Incentive amount is 75% of the physician's Medicare charges up to the payment year limit

Maximum Medicare Incentives for EPs in a non shortage area

2010	2011	2012	2013	2014	2015	2016	2017	
	Stage 1 \$18k	Stage 1 \$12k	Stage 2 \$8k	Stage 2 \$4k	Stage 3 \$2k	Stage 3	Stage 3	\$44k
		Stage 1 \$18k	Stage 1 \$12k	Stage 2 \$8k	Stage 3 \$4k	Stage 3 \$2k	Stage 3	\$44k
			Stage 1 \$15k	Stage 2 \$12k	Stage 3 \$8k	Stage 3 \$4k	Stage 3	\$39k
				Stage 1 \$12k	Stage 3 \$8k	Stage 3 \$4k	Stage 3	\$24k
					Stage 3	Stage 3	Stage 3	0
Penalty (deduction from Medicare charges) if not at stage 3 by January 1 of that year:					1%	2%	3%	

Maximum Medicare Incentives for EPs providing >50% Services in a Health Professional Shortage Area

2010	2011	2012	2013	2014	2015	2016	2017	
	Stage 1 \$19.8k	Stage 1 \$13.2k	Stage 2 \$8.8k	Stage 2 \$4.4k	Stage 3 \$2.2k	Stage 3	Stage 3	\$48.4k
		Stage 1 \$19.8k	Stage 1 \$13.2k	Stage 2 \$8.8k	Stage 3 \$4.4k	Stage 3 \$2.2k	Stage 3	\$48.4k
			Stage 1 \$16.5k	Stage 2 \$13.2k	Stage 3 \$8.8k	Stage 3 \$4.4k	Stage 3	\$42.9k
				Stage 1 \$13.2k	Stage 3 \$8.8k	Stage 3 \$4.4k	Stage 3	\$26.4k
					Stage 3	Stage 3	Stage 3	0
Penalty if not at stage 3:					1%	2%	3%	

Medicare Penalties

Penalties calculated as a percentage deduction from a provider's total allowed Medicare charges

Year	Penalty Amount
2015	1%
2016	2%
2017	3%
Beyond 2017*	3% - 5%*

*For 2018 and beyond, it was proposed that if less than 75% of eligible professionals are meaningful users, percentage shall increase by 1% each year but not be greater than 5%

Definition of an Medicare Eligible Hospital

- A subsection (d) hospital defined in the Social Security Act, essentially an acute care facility:
 - Located in the 50 states
 - Not a psychiatric, rehabilitative, predominately pediatric or cancer facility.
 - Where average length of stay is 25 days or less
- A critical access hospital

PPS EH Medicare Incentives

- $(\$2M + \text{Discharge Amount}) \times \text{Medicare Share} \times \text{Transition \%}$

Discharge amount:

$$\$200 \times (\# \text{ of discharges} \geq 1,150 \text{ and } \leq 23,000)$$

The Medicare share (MS):

$$\frac{\text{Medicare inpatient days}}{(\text{total inpatient days} \times ((\text{gross revenue} - \text{charity}) / \text{gross revenue}))}$$

Transition Percentage:

Based on the payment year and the fiscal year

Medicare Incentives for Eligible Hospitals

2010	2011	2012	2013	2014	2015	2016	2017
	Stage 1 100%	Stage 1 75%	Stage 2 50%	Stage 2 25%	Stage 3	Stage 3	Stage 3
		Stage 1 100%	Stage 1 75%	Stage 2 50%	Stage 3 25%	Stage 3	Stage 3
			Stage 1 100%	Stage 2 75%	Stage 3 50%	Stage 3 25%	Stage 3
				Stage 1 75%	Stage 3 50%	Stage 3 25%	Stage 3
					Stage 3 50%	Stage 3 25%	Stage 3
						Stage 3	Stage 3
Penalties for not achieving stage 3: 3/4ths of the applicable market basket update would be reduced by:					-33%	-66%	-100%



Incentive payments calculation: $(\$2,000,000 + \text{Discharge Amount}) \times (\text{Medicare Share}) \times (\text{Transition Percentage})$ Source: HIMSS

Eligible CAH Medicare Incentives

- Reasonable EHR costs × Medicare Share plus Reasonable EHR costs during the reporting period where the facility achieved meaningful use:
(acquisition cost EHR soft/hardware) – (depreciation + interest)
The Medicare share (MS):
$$\frac{\text{Medicare inpatient days}}{(\text{total inpatient days} \times ((\text{gross revenue} - \text{charity}) / \text{gross revenue}))}$$
Medicare Share plus:
MS% + 20% or 100% whichever is less
- Paid on an interim basis for a maximum of 4 years or through 2015
- Penalties:
 - 2015 reasonable cost reimbursement reduced to 100.66%, 100.33% in 2016 and 100% in 2017

Medicare Incentives for Critical Access Hospitals

2010	2011	2012	2013	2014	2015	2016	2017
	Stage 1 Payment	Stage 1 Payment	Stage 2 Payment	Stage 2 Payment	Stage 3	Stage 3	Stage 3
		Stage 1 Payment	Stage 1 Payment	Stage 2 Payment	Stage 3 Payment	Stage 3	Stage 3
			Stage 1 Payment	Stage 2 Payment	Stage 3 Payment	Stage 3	Stage 3
				Stage 1 Payment	Stage 3 Payment	Stage 3	Stage 3
					Stage 3 Payment	Stage 3	Stage 3
						Stage 3	Stage 3
Penalties for not achieving stage 3: Reasonable cost reimbursement of 101% would be reduced to:					100.66%	100.33%	100%



Incentive payments calculation based on the Medicare Share of the EHR cost

Eligible Provider Medicaid Incentives

- An Eligible Provider for Medicaid is defined as a
 - Physician
 - Dentist
 - Certified nurse mid-wife
 - Nurse practitioner
 - Physician assistant if the assistant is practicing in a rural health clinic or a federally qualified health center (FQHC) that is led by a physician assistant
- In order to be eligible for the Medicaid incentives, one must have
 - Greater than 30% Medicaid patient volume
 - Greater than 20% if a pediatrician
 - Greater than 30% “needy individuals” if at an FQHC or rural health clinic. The Social Security Act defines a needy individual as one who
 - Is receiving social security assistance
 - Is receiving assistance under title XXI the State Child Health Insurance Program (SCHIP)
 - Is furnished uncompensated care by the provider;
 - Has charges reduced by the provider on a sliding scale based on ability to pay.

Eligible Provider Medicaid Incentives, cont

- For providers with >30% Medicaid, incentive amount is 85% of the physician's allowable costs for the purchase, implementation and use of EHR technology up to the payment years' allowable cost limit
 - Allowable cost limit is \$25K year one and \$10K for the next 5 years
 - The first year payment can be as high as \$21,250 and \$8500 for each of the following 5 years
- For pediatricians with between 20 and 30% Medicaid, incentive amount is 56.67% of the physician's allowable costs for the EHR technology up to the payment years' allowable cost limit
 - The first year payment can be as high as \$14,167 and \$5,667 for each of the following 5 years
- The first payment year can be as late as 2016

Maximum Medicaid Incentives for Eligible Providers

		Adoption Year					
		2011	2012	2013	2014	2015	2016
Calendar Year	2011	\$21,250					
	2012	\$8,500	\$21,250				
	2013	\$8,500	\$8,500	\$21,250			
	2014	\$8,500	\$8,500	\$8,500	\$21,250		
	2015	\$8,500	\$8,500	\$8,500	\$8,500	\$21,250	
	2016	\$8,500	\$8,500	\$8,500	\$8,500	\$8,500	\$21,250
	2017		\$8,500	\$8,500	\$8,500	\$8,500	\$8,500
	2018			\$8,500	\$8,500	\$8,500	\$8,500
	2019				\$8,500	\$8,500	\$8,500
	2020					\$8,500	\$8,500
	2021						\$8,500
	Total	\$63,750	\$63,750	\$63,750	\$63,750	\$63,750	\$63,750

PPS EH Medicaid Incentives

- Payments over a 3 to 6 year period starting as late as 2016
- Non pediatric hospitals must have a Medicaid patient volume >10%
- Maximum aggregate payment is the calculated Medicaid share cost of EHR
- Aggregate Cost = Sum of payment years 1 to 4 of:
 $(\$2M + \text{Discharge Amount}) \times \text{Medicaid Share} \times \text{Transition \%}$
 Discharge amount:
 $\$200 \times (\# \text{ of discharges} \geq 1,150 \text{ and } \leq 23,000)$
 The Medicaid share (MS):

$$\frac{\text{Medicaid inpatient days}}{(\text{total inpatient days} \times ((\text{gross revenue} - \text{charity}) / \text{gross revenue}))}$$

 Transition Percentage:
 100% PY1, 75% PY2, 50% PY3, 25% PY4
- 1st payment year for adopting, implementing or upgrading certified EHR technology

Maximum Medicaid Incentives for Eligible PPS Hospitals

		Adoption Year					
		2011	2012	2013	2014	2015	2016
Calendar Year	2011	Y1					
	2012	Y2	Y1				
	2013	Y3	Y2	Y1			
	2014	Y4	Y3	Y2	Y1		
	2015	Y5	Y4	Y3	Y2	Y1	
	2016	Y6	Y5	Y4	Y3	Y2	Y1
	2017		Y6	Y5	Y4	Y3	Y2
	2018			Y6	Y5	Y4	Y3
	2019				Y6	Y5	Y4
	2020					Y6	Y5
	2021						Y6
Total:		Calculated Medicaid share or EHR Cost					

CAH's Medicaid Incentives

- Critical access hospitals are not eligible for Medicaid funding
- CMS defines an acute-care hospital as:
 - A section D hospital from the Social Security Act
 - Has a Medicare CCN with the last four digits in the series 0001 through 0879.
 - This excludes CAHs as well as psychiatric, rehabilitation, and long-term care hospitals.
- There has been significant concern about this exclusion in during the comment period

Medicaid Considerations

- State Medicaid Agencies may propose an alternative definition of meaningful use for Medicaid incentives, however...
 - States cannot propose fewer or less rigorous criteria
 - States cannot propose alternative that would require additional functionality beyond that of certified EHR technology
 - CMS must approve Medicaid Agencies' proposed definitions
 - State-specific MU definition would apply solely to EPs and children's hospitals

Medicaid Considerations, cont.

- Medicaid hospitals and eligible professionals can receive incentives for adoption, implementation and upgrade of certified EHR technology in their first year of participation
- “Adopt, implement, or upgrade” means:
 - Install or commence utilization of certified EHR technology capable of meeting meaningful use requirements; or
 - Expand the functionality of certified EHR technology capable of meeting meaningful use requirements at the practice site, including staffing, maintenance, and training.

Key Differences: Medicare & Medicaid

Medicare	Medicaid
CMS will implement (available nationally)	Voluntary for States to implement
Fee schedule reductions begin in 2015 for providers that are not Meaningful Users	No Medicaid fee schedule reductions (but Medicare penalties still apply)
Must be a meaningful user in Year 1	Adopt/Implement/Upgrade option for 1 st participation year
MU definition will be common for Medicare	States can adopt a more rigorous definition (based on common definition) though hospitals only have to meet the Medicare definition if they participate in both
Last year an EP may initiate program is 2014; Last payment in program is 2016. Payment adjustments begin in 2015	Last year an EP may initiate program is 2016; Last payment in program is 2021
Only physicians, subsection (d) hospitals and CAHs	5 types of EPs, acute care and children's hospitals

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Broad Goals for Meaningful Use

Vision

- Enable significant and measurable improvements in population health through a transformed health care delivery system.

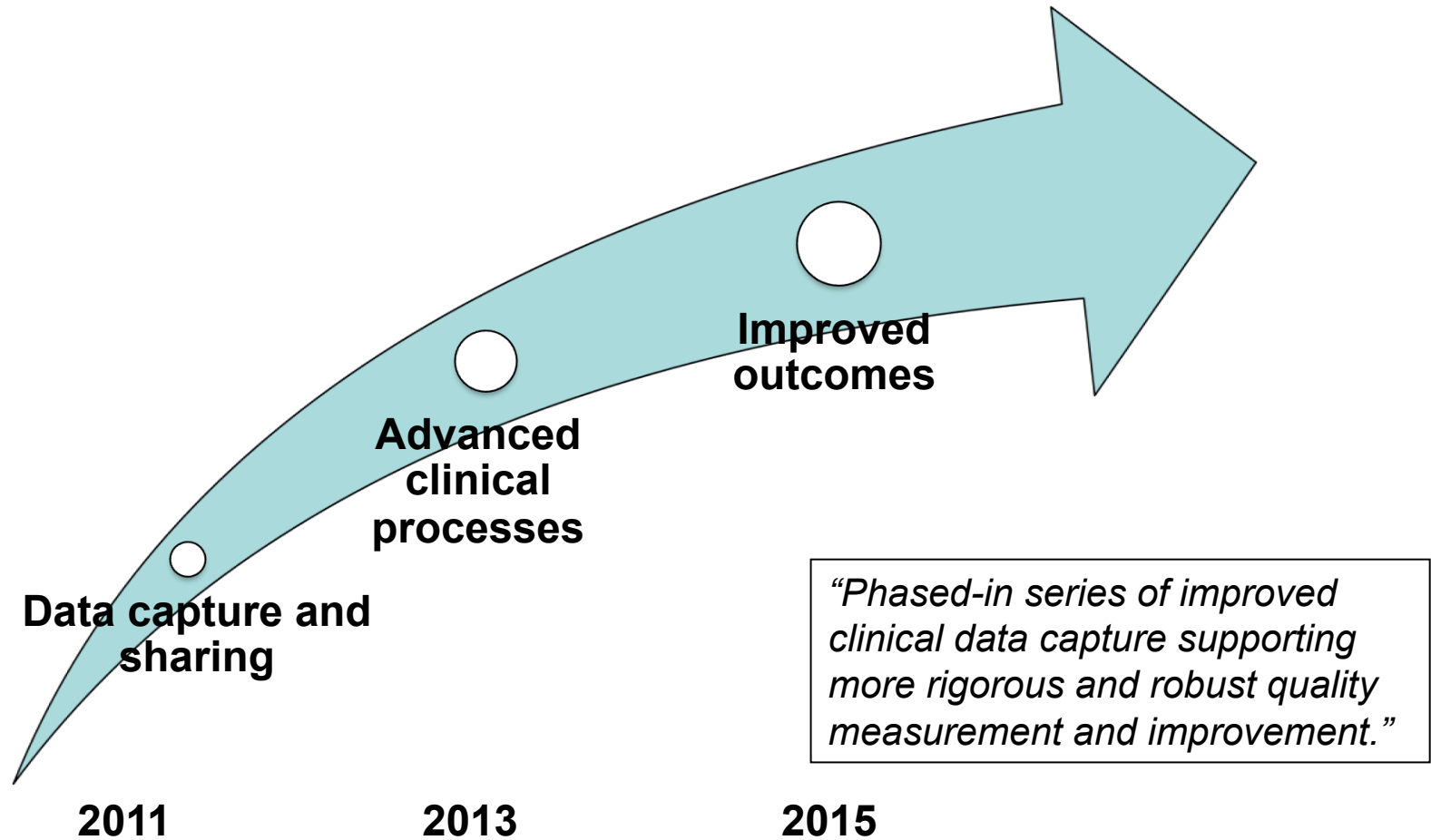
Goals*

1. Improve quality, safety, efficiency and reduce health disparities.
2. Engage patients and families.
3. Improve care coordination.
4. Improve population and public health.
5. Ensure adequate privacy and security protections for personal health information.

Meaningful Use Evolution

- The proposed rule lays out three stages to be applied to providers and hospitals seeking to receive incentive payments:
 - The first stage will be applied to all those seeking to meet the requirements when the program launches in FY 2011 (hospitals) and CY 2011 (providers).
 - The second and third stages, which will be proposed in late 2011 and late 2013, will apply to providers and hospitals as they progress in their meaningful use of EHRs.

Bending the Curve Towards Transformed Health



Reactions to the Incentive NPRM

- Allow Critical Access Hospitals to be eligible for Medicaid incentives
- Define the calculation of a hospital based EP as the encounter location and not as the location of the charges
- Remove the reporting of quality measures from the stage 1 criteria until they can be done electronically
- Move medication reconciliation across care locations to 2013
- Greater flexibility in meeting meaningful use criteria – not all or none allowing EPs and EHs the to defer 3-1-1-1-0 non-mandatory item from each category (bolded on the following slides) in the first year
- Use a different set of measurements for CAH's – do not include CPOE in Stage 1

Meaningful Use Criteria

Organized according to the Health Outcomes Policy
Priorities:

- Improving quality, safety, efficiency, and reducing health disparities
- Engage patients and families in their health care
- Improve care coordination
- Improve population and public health
- Ensure adequate privacy and security protections for personal health information

Improve quality, safety, efficiency and reduce health disparities

Care Goals:

- Provide access to comprehensive patient health data for patient's health care team
- Use evidence- based order sets and CPOE
- Apply clinical decision support at the point of care
- Generate lists of patients who need care and use them to reach out to patients
- Report information for quality improvement, public reporting

Improve quality, safety, efficiency and reduce health disparities

Objective	Ambulatory Measure	Hospital Measure
CPOE	80% of all orders	10 % of all orders
ePrescribe	75% of permissible scripts	-
Demographics	80% of patients seen: language, insurance, gender, race, ethnicity, DOB	80% of patients seen: language, insurance, gender, race, ethnicity, DOB, date and cause of death
Quality Reporting	Report specialty specific quality measures to CMS or states	Report specialty specific quality measures to CMS or states
Drug Interactions	Turned on (attestation)	Turned on (attestation)
Med List	80% of patients seen at least one or "none"	80% of patients seen at least one or "none"
Med Allergies	80% of patients seen at least one or "none"	80% of patients seen at least one or "none"

Improve quality, safety, efficiency and reduce health disparities cont.

Objective	Ambulatory Measure	Hospital Measure
Problem List	80% of patients seen at least one or “none”	80% of patients seen at least one or “none”
Vitals	80% of patients seen: height, weight, BP, BMI, & for age 2-20: growth charts	80% of patients seen: height, weight, BP, BMI, & for age 2-20: growth charts
Smoking	80% of patients ≥ age 13, record status	80% of patients ≥ age 13, record status
Lab Results	50% of labs with numeric or +/- result in chart as structured data	50% of labs with numeric or +/- result in chart as structured data
Patient Lists	Generate pt lists (attestation)	Generate pt lists (attestation)
Reminders	50% of pts ≥ 50 sent reminders for follow up care	-

Improve quality, safety, efficiency and reduce health disparities cont.

Objective	Ambulatory Measure	Hospital Measure
Decision Support	5 CDS rules relevant to the specialty specific quality metric	5 CDS rules relevant to the specialty specific quality metric
Insurance Eligibility	80% of patients seen	80% of patients seen
Electronic claim submission	80% of patients seen	80% of patients seen

Engage Patients and Families in Their Health Care

Care Goal:

- Provide patients and families with timely access to data, knowledge, and tools to make informed decisions and to manage their health

Objective	Ambulatory Measure	Hospital Measure
eDischarge info	-	80% of patients who request it (incl: d/c instructions, procedures)
Visit summaries	80% of patients seen get visit summary	-
eResults	10% patients seen with electronic access to lab results, prob lists, med list, allergies	-
eHealth summary	80% of patients who request it (incl: test results, prob list, med list allergies)	80% of patients who request it (incl: test results, prob list, med list allergies. d/c summary, procedures)

Improve Care Coordination

Care Goal:

- Exchange meaningful clinical information among professional health care teams

Objective	Ambulatory Measure	Hospital Measure
Exchange with providers	Electronic exchange of prob list, med list, allergies, test results. One attempt year one (Attestation)	Electronic exchange of prob list, med list, allergies, test results, procedures, d/c summary. One attempt year one (Attestation)
Medication reconciliation	80% of relevant encounters and transitions of care	80% of relevant encounters and transitions of care
Referral summary	80% of referrals and transitions of care	80% of referrals and transitions of care

Improve Population and Public Health

Care Goal:

- Communicate with public health agencies

Objective	Ambulatory Measure	Hospital Measure
Immunization records	One test of submission to state immunization registry (attestation)	One test of submission to state immunization registry (attestation)
Reportable labs	-	One test of submission to state public health agency (attestation)
Syndromic Surveillance	One test of submission to state public health agency (attestation)	One test of submission to state public health agency (attestation)

Privacy and security protections for personal health information

Care Goal:

- Ensure privacy and security protections for confidential information through operating policies, procedures, and technologies and compliance with applicable law.
- Provide transparency of data sharing to patient.

Objective	Ambulatory Measure	Hospital Measure
Protect Patient PHI	Conduct or review a security risk analysis per 45 CFR 164.308 (a)(1) and implement security updates as necessary (Attestation)	Conduct or review a security risk analysis per 45 CFR 164.308 (a)(1) and implement security updates as necessary (Attestation)

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Quality Measures

- Relate to healthcare quality aims such as effective, safe, efficient, patient-centered, equitable, and timely care.”
- Includes “measures of processes, experience, and/or outcomes of patient care, observations or treatment
 - Draws primarily from PQRI and NQF endorsed measures
 - NQF is modifying existing quality measures to meet MU requirements
- Quality reporting will be done by attestation in 2011
 - Reporting not limited to Medicare or Medicaid patients
- CMS is reviewing comments on the clinical utility of the measures, as well as their readiness for use in the incentive programs

Reporting of Clinical Quality Measures

- EPs would be required to submit clinical data on 2 measure groups: core measures and a subset of clinical measures most appropriate to the EP's specialty
- EHs would be required to submit a single set of measures
- Patient information must be submitted regardless of payer
- Some, but not all, measures:
 - Are currently reported (although not via EHRs) under existing Medicare pay-for-reporting programs
 - Are currently calculated based on chart abstracts
 - Have specifications for electronic reporting

Quality Measures

Core for All EPs, Medicare or Medicaid

Measure Number	Clinical Quality Measure Title
PQRI 114 NQF 0028	Preventive Care and Screening: Inquiry Regarding Tobacco Use
NQF 0013	Blood pressure measurement
NQF 0022	Drugs to be avoided in the elderly: a. Patients who receive at least one drug to be avoided. b. Patients who receive at least two different drugs to be avoided

Specialty Quality Measures

All EPs will need to select one or more of the following specialties:

Cardiology	Obstetrics and Gynecology
Pulmonology	Neurology
Endocrinology	Psychiatry
Oncology	Ophthalmology
Proceduralist/Surgery	Podiatry
Primary Care	Radiology
Pediatrics	Gastroenterology
Nephrology	

Proposed Quality Measures for Primary Care

Measure Number	Clinical Quality Measure Title & Description
PQRI 114, NQF 0028	Preventive Care and Screening: Inquiry Regarding Tobacco Use
PQRI 115, NQF 0027	Preventive Care and Screening: Advising Smokers to Quit
PQRI 202, NQF 0075	Ischemic Vascular Disease (IVD): Complete Lipid Profile
PQRI 203, NQF 0075	Ischemic Vascular Disease (IVD): Low Density Lipoprotein (LDL-C) Control
PQRI 204, NQF 0068	Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antithrombotic
NQF 0038	Childhood Immunization Status
PQRI 112, NQF 0031	Preventive Care and Screening: Screening Mammography
PQRI 113, NQF 0034	Preventive Care and Screening: Colorectal Cancer Screening

Measure Number	Clinical Quality Measure Title & Description
PQRI 1, NQF 0059	Diabetes Mellitus: Hemoglobin A1c Poor Control in Diabetes Mellitus
NQF 0052	Low back pain: use of imaging studies
NQF 0018	Controlling High Blood Pressure
PQRI 128, NQF 0421	Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up
PQRI 65, NQF 0069	Treatment for Children with Upper Respiratory Infection (URI): Avoidance of Inappropriate Use
PQRI 66, NQF 0002	Appropriate Testing for Children with Pharyngitis
PQRI 110, NQF 0041	Preventive Care and Screening: Influenza Immunization for Patients ≥ 50 Years Old
PQRI 197, NQF 0074	Coronary Artery Disease (CAD): Drug Therapy for Lowering LDL Cholesterol

Proposed Quality Measures for Primary Care, Cont.

Measure Number	Clinical Quality Measure Title & Description
PQRI 197, NQF 0074	Coronary Artery Disease (CAD): Drug Therapy for Lowering LDLCholesterol
NQF 0001	Asthma Assessment
NQF 0004	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment: (a) Initiation, (b) Engagement
NQF 0024	Body Mass Index (BMI) 2 through 18 years of age
NQF 0032	Cervical Cancer Screening
NQF 0036	Use of appropriate medications for people with asthma
NQF 0060	Hemoglobin A1c test for pediatric patients
NQF 0105	New Episode of Depression: (a) Optimal Practitioner Contacts for Medication Management, (b) Effective Acute Phase Treatment, (c) Effective Continuation Phase Treatment

Measure Number	Clinical Quality Measure Title & Description
NQF 0106	Diagnosis of attention deficit hyperactivity disorder (ADHD) in primary care for school age children and adolescents
NQF 0107	Management of attention deficit hyperactivity disorder (ADHD) in primary care for school age children and adolescents
NQF 0108	ADHD: Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication.
NQF 0110	Bipolar Disorder and Major Depression: Appraisal for alcohol or chemical substance use
	Comprehensive Diabetes Care: HbA1c Control (<8.0 percent)
	Appropriate antibiotic use for ear infections

Quality Measures

For Eligible Hospitals

- In 2011 payment year eligible hospitals will be required to report summary data to CMS on the set of clinical quality measures identified in Table 20 (next slides)
- For the 2012 payment year, hospitals will be required to submit these measures to CMS electronically to meet the requirements for both the Medicare and the Medicaid EHR incentive if eligible for both
- For hospitals eligible for only the Medicaid incentive program they will report to States
- For eligible hospitals to which the measures do not apply to their population, they will have other measures to meet the Medicaid reporting requirements

35 Quality Measures for EHs

- ED Throughput – admitted patients Median time from ED arrival to ED departure for admitted patients
- ED Throughput – admitted patients Admission decision time to ED departure time for admitted patients
- ED Throughput – discharged patients Median Time from ED Arrival to ED Departure for Discharged ED Patients
- Ischemic stroke – Discharge on anti-thrombotics
- Ischemic stroke – Anticoagulation for A-fib/flutter
- Ischemic stroke – Thrombolytic therapy for patients arriving within 2 hours of symptom onset
- Ischemic or hemorrhagic stroke – Antithrombotic therapy by day 2
- Ischemic stroke – Discharge on statins
- Ischemic or hemorrhagic stroke – Stroke education
- Ischemic or hemorrhagic stroke – Rehabilitation assessment
- VTE prophylaxis within 24 hours of arrival
- ICU VTE prophylaxis
- Anticoagulation overlap therapy
- Platelet monitoring on unfractionated heparin
- VTE discharge instructions
- Incidence of potentially preventable VTE
- Primary PCI Received Within 90 Minutes of Hospital Arrival
- Blood Cultures Performed in the ED Prior to Initial Antibiotic Received in Hospital
- Aspirin Prescribed at Discharge

35 Quality Measures for Ehs *(Cont.)*

- Angiotensin Converting Enzyme Inhibitor (ACEI) or Angiotensin Receptor Blocker (ARB) for Left Ventricular Systolic Dysfunction (LVSD)
- Beta-Blocker Prescribed at Discharge
- Hospital Specific 30 day Risk-Standardized Readmission Rate following AMI admission
- Hospital Specific 30 day Rate following AMI admission
- Hospital Specific 30 day Risk-Standardized Readmission Rate following Heart Failure admission
- Hospital Specific 30 day Rate following Heart Failure admission
- Hospital Specific 30 day Risk-Standardized Readmission Rate following Pneumonia admission
- Hospital Specific 30 day Rate following Pneumonia admission
- Infection SCIP Inf-2 Prophylactic antibiotics consistent with current recommendations
- Ventilator Bundle
- Central Line Bundle Compliance
- Ventilator-associated pneumonia for ICU and high-risk nursery (HRN) patients
- Urinary catheter-associated urinary tract infection for intensive care unit (ICU) patients
- Central line catheter-associated blood stream infection rate for ICU and high-risk nursery (HRN) patients
- All-Cause Readmission Index (risk adjusted)
- All-Cause Readmission Index

Outline

- The Drivers
- The Recovery Act
- Financial Incentives for Hospitals and Providers
- Proposed Elements of Meaningful Use
- Proposed Quality Measures
- **What You Can Do**
 - Regional Extension Centers for HIT

What should you do if you don't have an EHR?

- **Engage with your Regional Extension Center**
- Create a group vision of where you want to be in 5 years
- Engage the entire staff in talking about adopting an EHR
- Seek out the experience of others who have done it already
- Be up front that the transition, either installation or optimization, will be difficult, but worth it
- Begin to accurately record allergies, medications, medical and surgical histories in the chart and create a process to collect and verify these
- As you start the process, involve employees and medical staff throughout your facility in your EHR implementation committees
- Begin to clean up your process now so it is not blamed on the EHR

What should you do if you do have an EHR?

- **Engage with your Regional Extension Center**
- Make sure it is a “certified” EHR
- Evaluate whether or not you are taking full advantage of your investment
- Seek out the experience of others
- Help support everyone in your facility to use it in a “meaningful” way
- Positively engage your whole team in EHR optimization, meaningful use and workflow redesign
- For providers: practice completing your charting while the patient is in the room

Health Information Technology (HIT) Regional Extension Centers

- Funded by the Recovery Act
- Provide substantially subsidized services for *priority primary care providers* and for small and Critical Access hospitals
- Designed to assist in selection, implementation and optimization of an EHR to bring all users, with or without an EHR, to the point of Meaningful Use
- Greatest subsidy occurs during the first two years of the program

Defining priority providers

- Subsidized services offered to priority primary care providers defined as:
 - Physicians and health care professionals with prescriptive privileges
 - Physicians, physician assistants, nurse practitioners, nurse midwives
 - Focused on primary care
 - Family medicine, internal medicine, Ob/Gyn, pediatrics
 - In individual and small practices (10 or fewer professionals with prescriptive privileges)
- Primary care providers in larger clinics will also benefit from the subsidies
- Services also available for multi-specialty clinics

Regional Extension Center (REC) Approach

- Process consultation approach
 - Providers gain skills and tools to make their own changes in an informed and sustainable way
- Organizational change factors critical for success
 - Leadership, culture, process, workflow redesign
- A companion to Medicare and Medicaid incentives
 - Assist primary care provider and small hospitals to achieve meaningful use of their EHR
 - Enables eligible providers to earn their Medicare/Medicaid incentive payments

REC technical assistance

- Vendor selection and group purchasing
- Implementation and project management
- Practice and workflow redesign
- Functional interoperability and HIE
- Privacy and security
- Progress towards meaningful use
- Local workforce support

What makes RECs different?

- Unbiased assistance
 - Not supported by vendors in any way
- Pooling years of experience among the RECs
 - Working with clinics and small hospitals
- Significant subsidies
 - Available the first two years
- Skin in the game
 - If you do not achieve meaningful use, RECs only receive a portion of the federal dollars for their work

Most importantly, remember why we are doing this

We are doing this to:

- Improve the quality, safety and efficiency of care while reducing health disparities
- Engage our patients and their families in their care
- Improve care coordination
- Improve population and public health
- Ensure adequate privacy and security protections for everyone's personal health information

Resources:

- “Meaningful Use” information on the Health and Human Services web site:
 - <http://healthit.hhs.gov/meaningfuluse>
- Information about the HIT Extension Centers:
 - http://healthit.hhs.gov/portal/server.pt?open=512&objID=1495&parentname=CommunityPage&parentid=58&mode=2&in_hi_userid=11113&cached=true
 - (or go to “<http://healthit.hhs.gov/>,” select “HITECH Programs” in the left column, then select “Health Information Technology Extension Program”)
- REACH Toolkits for Clinics and Critical Access Hospitals:
 - <http://www.stratishealth.org/expertise/healthit/>

Questions?

Paul Kleeberg, MD

Clinical Director

REACH—Regional Extension Assistance Center for HIT (MN & ND)

pkleeberg@stratishealth.org

952-853-8552

To find out more information about REACH

<http://khaREACH.org>

877-331-8783, ext. 222



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