

Improving Care through Health IT: The Time is Now!



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Agenda

- Stratis Health
- State HIT environment
- Federal HIT environment
 - Medicare and Medicaid incentive for Meaningful Use (MU)
 - Regional Extension Centers (REC)
 - Health Information Exchange (HIE)
 - HIT Workforce development
 - Beacon
 - Strategic Health Information Technology Advanced Research Projects (SHARP)
- Resources

Stratis Health

- Nonprofit organization that leads collaboration and innovation in health care quality and safety, and serves as a trusted expert in facilitating improvement for people and communities
- Serves as Minnesota's Medicare Quality Improvement Organization (QIO)
- Part of Key Health Alliance (Stratis Health, Rural Health Resource Center, and The College of St. Scholastica) which was recently awarded the HIT Regional Extension Center contract for Minnesota and North Dakota
- Involved in other state and national projects funded through government contracts, foundation and corporate grants, and health systems
- HIT experience
 - HIT toolkits
 - Education and technical assistance
 - HIT surveys
 - Policy

State HIT Requirements

2011 Electronic Prescribing Mandate and Standards

Requirements for electronic prescribing. (a) Effective January 1, 2011, all providers, group purchasers, prescribers, and dispensers must establish and maintain an electronic prescription drug program that complies with the applicable standards in this section for transmitting, directly or through an intermediary, prescriptions and prescription-related information using electronic media.

2015 Interoperable Electronic Health Record Mandate

By January 1, 2015, all hospitals and health care providers must have in place an interoperable electronic health records system within their hospital system or clinical practice setting.

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
- Care is expensive yet quality is low
- HIT is a tool for improving quality
- 6 grant funded initiatives- to move medicine into the 21st Century

HITECH Funding Initiatives

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 . 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 and network architectures, and secondary use of EHR data

MU 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

Incentive Program Key Provisions

Eligibility

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

“Stage 1” Meaningful Use Criteria

- 25 objectives and measures for eligible professionals (EP)
 - 15 are required, up to 5 of the remaining 10 may be deferred to Stage 2
 - 8 require attestation; 17 require data submission
- 24 objectives and measures for eligible hospitals (EH)
 - 14 are required, up to 5 of the remaining 10 may be deferred to Stage 2
 - 9 require attestation; 15 require data submission
- In 2012, clinical quality metrics will be reported electronically
- To meet certain objectives/measures, 80% of patients seen during the reporting period must have records in the certified EHR technology

Incentive Program Key Provisions (cont.)

Timeframe for Demonstrating Meaningful Use (MU):

- In the 1st year of demonstrating meaningful use, hospitals and each provider must demonstrate MU over any continuous 90 period.
 - Note: This could be the second payment year if money was received from Medicaid for adopt, implement, upgrade
- For subsequent years hospitals and individual providers must demonstrate MU over the entire reporting year.

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 or 23 (considered hospital inpatient or ED based)
- If at multiple sites, must have certified EHR technology available for $\geq 50\%$ of their patient encounters
- Incentive amount is 75% of the physician's Medicare allowable charges up to the payment year limit

Maximum Medicare Incentives for EPs in a non shortage area¹

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

1. Providers with >50% Medicare services (as opposed to charges) in a health professional shortage area see a 10% increase in the maximum payment

Incentive Payments to Eligible Providers

- Made either directly to the provider or the provider may reassign it to another entity
- Providers who work in multiple sites and achieve MU by combining the work they did at multiple sites, still may only assign their payment to one entity
- In the first year of demonstrating MU, a payment will be made when the provider reaches his/her Medicare allowable charges limit or the end of the year, whichever comes first

Medicaid Eligible Provider

- An Eligible Provider for Medicaid is defined in statute as a
 - Physician (MD, DO and in some states, optometrists)
 - Dentist
 - Certified nurse mid-wife
 - Nurse practitioner
 - Physician assistant if the assistant is practicing in either a rural health clinic (RHC) or a federally qualified health center (FQHC) that is led by a physician assistant
- PA would be leading an FQHC or RHC if:
 - A PA is the primary provider in a clinic (for example, when there is a part-time physician and full-time PA, we would consider the PA as the primary provider)
 - A PA is a clinical or medical director at a clinical site of practice
 - A PA is an owner of an RHC.

Medicaid Eligible Provider (cont.)

- 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 > 50% encounters at an FQHC or rural health clinic.
 - The Social Security Act defines a needy individual¹ as one who
 - Is receiving assistance under Medicaid
 - 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 based on ability to pay.
 - Volume can be calculated by clinic in most instances
 - No minimum patient volume required
 - Volume is defined as services rendered on any one day to an individual

1. http://www.socialsecurity.gov/OP_Home/ssact/title19/1903.htm#act-1903-t-3-f

Eligible Provider Medicaid Incentives

- 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 and limit is reduced by 1/3
 - 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 EPs with $\geq 30\%$ volume

		Year of Adopt, implement, Upgrade or MU Demonstration						
		2011	2012	2013	2014	2015	2016	2011
Calendar Year	2011	\$21,250						\$21,250
	2012	\$8,500	\$21,250					
	2013	\$8,500	\$8,500	\$21,250				\$8,500
	2014	\$8,500	\$8,500	\$8,500	\$21,250			
	2015	\$8,500	\$8,500	\$8,500	\$8,500	\$21,250		\$8,500
	2016	\$8,500	\$8,500	\$8,500	\$8,500	\$8,500	\$21,250	\$8,500
	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	\$8,500
	2020					\$8,500	\$8,500	
	2021						\$8,500	\$8,500
	Total	\$63,750	\$63,750	\$63,750	\$63,750	\$63,750	\$63,750	\$63,750

Differences Between Medicare & Medicaid EHR Programs

Medicare	Medicaid
Federal Government will implement (available nationally)	Voluntary for States to implement (may not be an option in every State)
Fee schedule reductions begin in 2015 for providers that do not demonstrate Meaningful Use	No Medicaid fee schedule reductions (but Medicare penalties still apply)
Must demonstrate meaningful use in Year 1	Adopt/Implement/Upgrade option for 1 st participation year
Maximum incentive is \$44,000 for EPs (bonus for EPs in HPSAs)	Maximum incentive is \$63,750 for EPs
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
Payment years must be consecutive	Payment years needn't be consecutive for EPs but must be for EHs after 2016
Only physicians, subsection (d) hospitals and CAHs	5 types of EPs, acute care hospitals (including CAHs) and children's hospitals

Adapted from: CMS presentation July 20, 2010

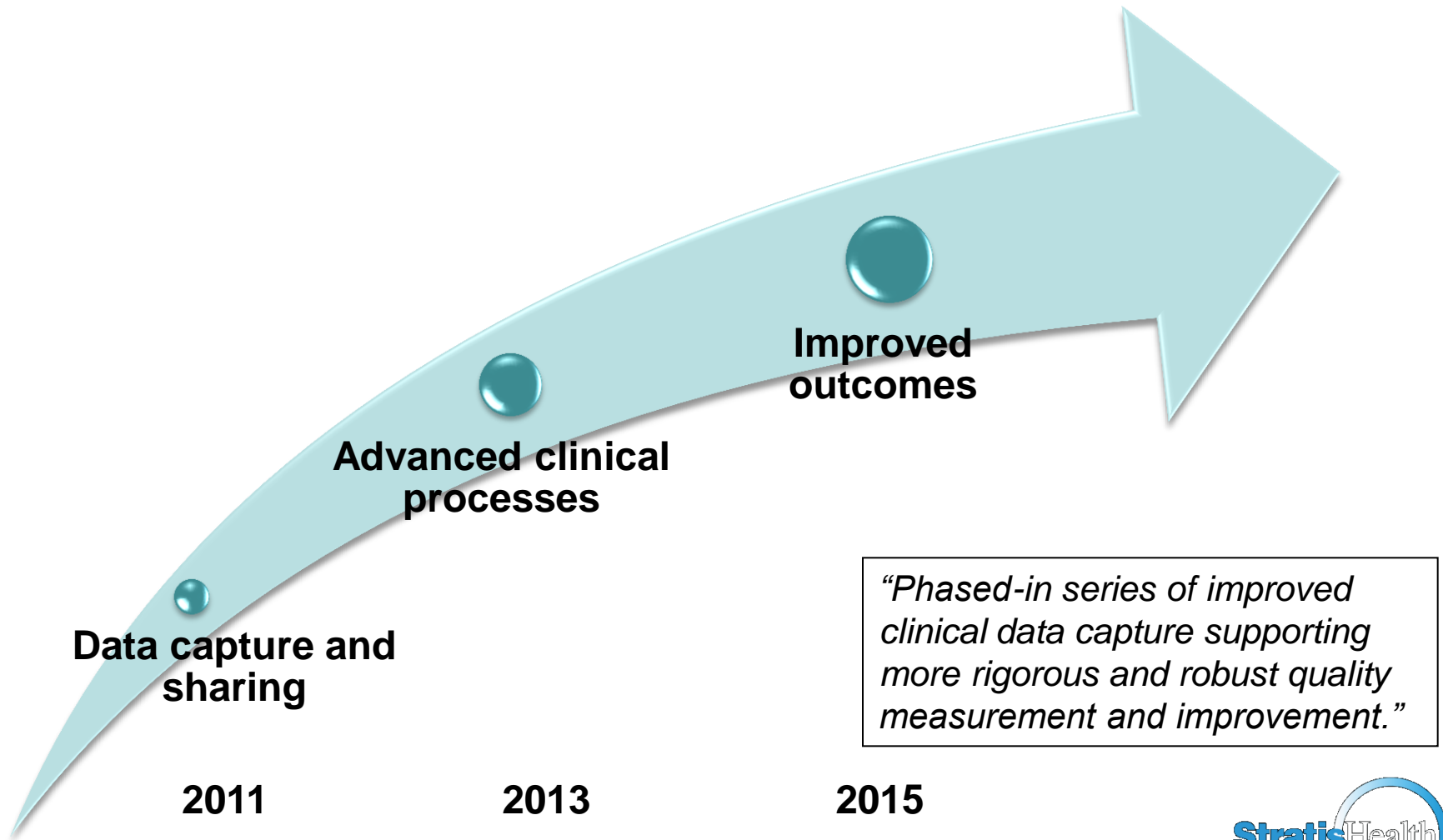


Meaningful Use Criteria

- Organized according to the Health Outcomes Policy Priorities:¹
 - 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
- Are divided into Core Criteria and Menu Criteria

1. Adapted from National Priorities Partnership. National Priorities and Goals: Aligning Our Efforts to Transform America's Healthcare. Washington, DC: National Quality Forum; 2008.

Bending the Curve Towards Transformed Health



Source: Connecting for Health, Markle Foundation “Achieving the Health IT Objectives of the American Recovery and Reinvestment Act” April 2009

Progression of the Stages:

- The Stage 1 meaningful use criteria focus on
 - Electronically capturing health information in a structured format
 - Using that information to track key clinical conditions and communicating that information for care coordination purposes
 - Implementing clinical decision support tools to facilitate disease and medication management
 - Using EHRs to engage patients and families and reporting clinical quality measures and public health information.

Mental Health Providers

April 2010

Bill Would Expand Eligibility for 'Meaningful Use' Incentives

- Reps. Patrick Kennedy (D-R.I.) and Tim Murphy (R-Pa.) introduced a bill ([HR 5025](#)) that would allow behavioral, mental health and substance abuse treatment providers to qualify for incentive payments for the "meaningful use" of electronic health records, [Healthcare IT News](#) reports.
- Under the 2009 federal economic stimulus package, hospitals and physicians who demonstrate meaningful use of EHRs can qualify for incentive payments through Medicaid and Medicare.
- The new Health Information Technology Extension for Behavioral Health Services Act of 2010 would extend eligibility for the incentive payments to:
- Behavioral and mental health professionals and clinics;
 - Substance abuse professionals and treatment facilities;
 - Psychiatric hospitals; and
 - Licensed psychologists and clinical social workers (Merrill, *Healthcare IT News*, 4/16).

Read more: <http://www.ihealthbeat.org/articles/2010/4/16/bill-would-expand-eligibility-for-meaningful-use-incentives.aspx#ixzz1019NT4TE>

Regional Extension Assistance Center for HIT (REACH)

- Project of Key Health Alliance: Stratis Health, National Rural Health Resource Center, and The College of St. Scholastica
 - Strong track record of success in HIT and EHR technical assistance and support
- Working in close cooperation with:
 - North Dakota Health Care Review, Inc.
 - University of ND, Center for Rural Health



Federally Subsidized Services

- Providers without an EHR or with an EHR who wish to achieve meaningful use and beyond
- Greatest discount for primary care providers, defined as:
 - Physicians and health care professionals with prescriptive privileges
 - Physicians, physician assistants, nurse practitioners, nurse midwives
 - Providing primary care
 - Family medicine, internal medicine, Ob/Gyn, pediatrics
- Subsidized services also available
 - Large multispecialty clinics with primary care providers
- Nonprofit rates available for specialty clinics and other settings of care
- Small and Critical Access Hospital funding just announced

REACH Approach

- EHR Roadmap guides consultation process
- Focus on organizational change required for success
 - Leadership, culture, workflow redesign
- Provide tools to support your HIT sustainability
- Medicare and Medicaid incentives companion
 - Assist primary care providers and small hospitals to achieve meaningful use of their EHR
 - Enables eligible providers to qualify for Medicare/Medicaid incentive payments

REACH Technical Assistance

- Readiness assessments
 - Evaluate your strengths and opportunities to prepare your organization for EHR adoption and effective use
- Practice and workflow redesign
 - Reevaluate workflows and processes for EHR to be an efficient tool
- Assist in selecting a certified EHR product that offers the best value for your needs
 - From developing your system requirements/needs through helping you identify the right vendor for you
- Vendor contracting
 - Provide contract coaching to ensure you get a fair deal from your vendor
- Process for EHR project management
 - Help you to develop a process to work with your selected vendor to ensure effective implementation of a certified EHR product

REACH Technical Assistance

- EHR optimization and meaningful use
 - Assist with leveraging your EHR's potential to improve quality and value of care by enhancing clinical and administrative workflows, focusing on process improvement, and guidance in template building and clinical decision support
- Technical reporting
 - Assist with technical services to support attestation and quality data submission to CMS, i.e., Crystal Report writing, SQL programming
- Privacy and security best practices for your EHR
 - Training to enable you to comply with legal requirements to protect patient health information, i.e., breach notification, risk mitigation, policy and procedure templates, business associate management
- Functional interoperability and HIE
 - Assessment and guidance from basics of e-prescribing to preparing you to participate in health information exchange with other provider organizations and other entities for things such as the immunization registry, public health and quality reporting

Providers well on their way to MU

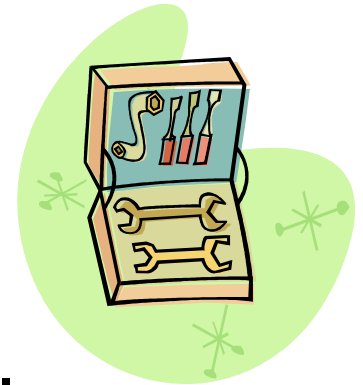
- Helping you achieve 2011 criteria for meaningful use and preparing you for 2013 and 2015 criteria
- Meaningful use criteria are based on National Priorities Partnership goals for transforming America's Healthcare
 - Improve quality, safety, efficiency and reduce health disparities
 - Engage patients and families in their care
 - Improve care coordination across locations of care
 - Improve population and public health
 - Ensure adequate privacy and security protections for personal health information
- Subsidized services for activities that help you achieve these goals

REACH Subsidies

- Subsidies for services are based upon meeting milestones toward meaningful use
- To receive greatest REACH subsidies and CMS incentives, you must be certified for meaningful use by January 2012

Physician Office Toolkit

- Kick start your HIT and EHR planning
- Formalize the process
- Reduce your cost
- Serve as surrogate staff
- Achieve your HIT and EHR goals



HIT =

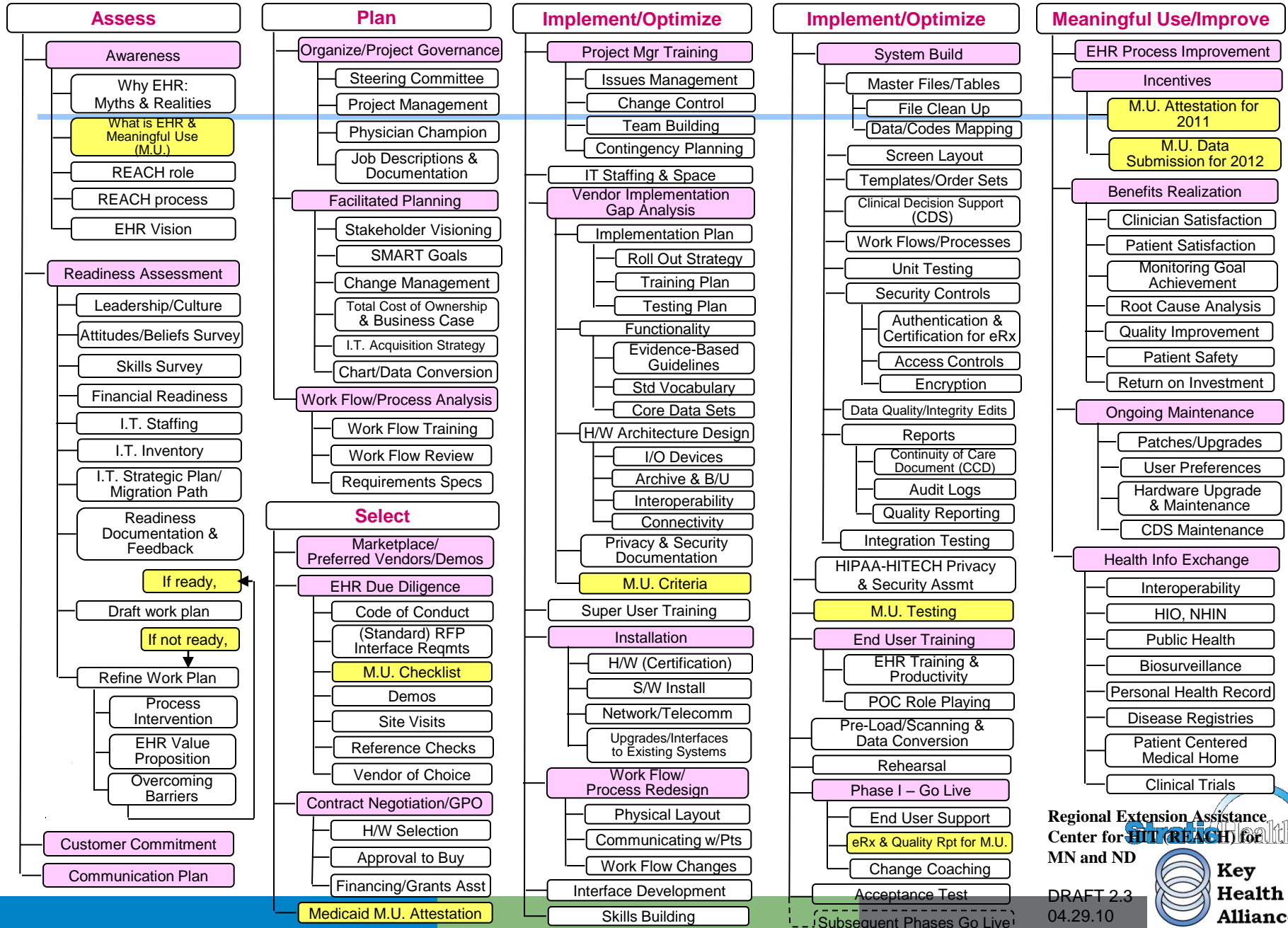
General term relating to any use of information technology in health care

EHR =

Specific term referring to the information system applications collectively used by clinicians that support decision making at the point of care

KHA REACH TECHNICAL ASSISTANCE ROADMAP OVERVIEW

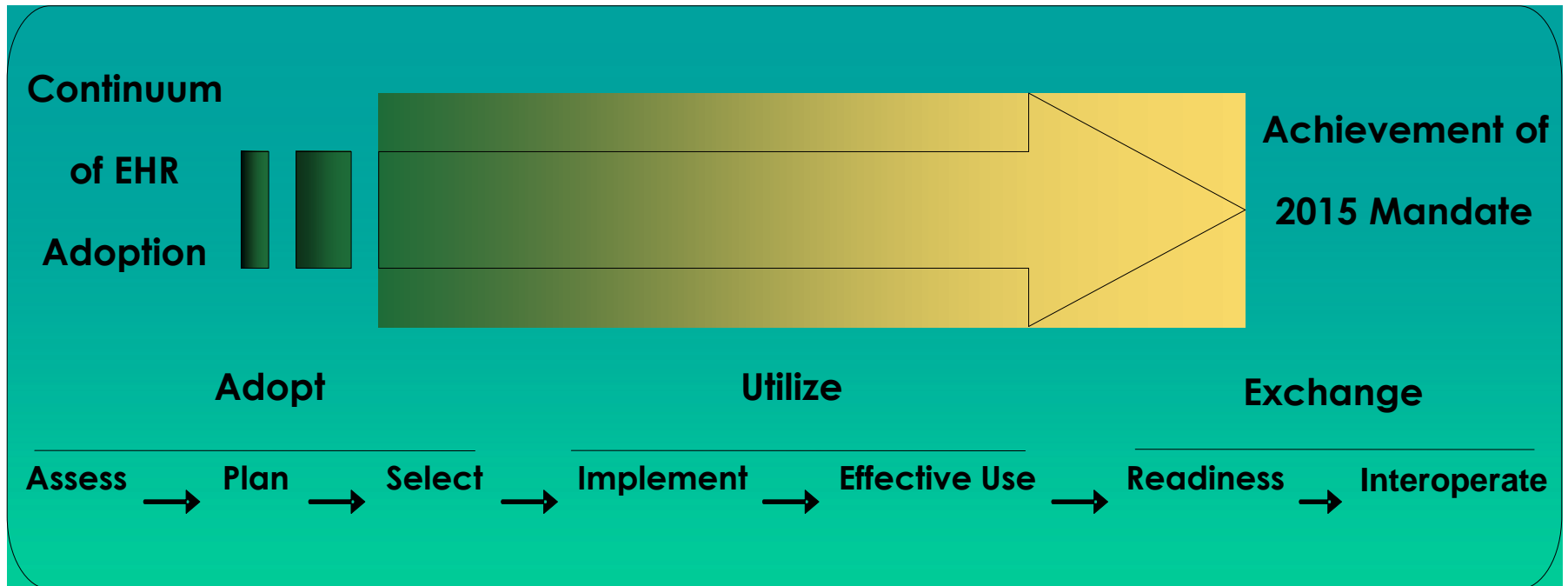
This roadmap will be used to develop a work plan modified for each organization to reflect its stage of EHR migration.



Types of Tools

- **Recorded Webinars**
 - Short (15-20 minute) educational tools
 - Walk through use of key tools
 - Introduce key topics for your HIT team, EHR steering committee, staff, community
 - Stimulate team discussion
- **Survey forms, checklists, comparisons, charts, tip sheets, interview tools, rating forms, other tools**
- **Sample job descriptions, policies and procedures, request for proposal, other model documents**

Adopting Interoperable EHRs



Minnesota Department of Health, February 2008

Resources

- REC www.khareach.org
- Stratis Health toolkit www.stratishealth.org
- MN e-Health <http://www.health.state.mn.us>
- MN EHR Loan Program
<http://www.health.state.mn.us/e-health/ehrloanguidance08.pdf>
- Meaningful Use
<http://healthit.hhs.gov/meaningfuluse>

For More Support

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