The Road to Robust Use of HIT: Navigating Meaningful Use and Beyond

by

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Presentation Objectives

Participants will be able to:

• Verbalize the role Regional Extension Centers play in HIT implementation
• Describe the updated timeline for Meaningful Use (MU) Stage 2
• Describe the changes between Stage 1 and Stage 2 MU
• Understand the impact of MU on hospitals and patients
• Understand what is important when implementing an EHR to ensure robust use of the functionality
• Identify best practices, tools and resources
Vision

• A health system that uses information to empower individuals and to improve the health of the population

Mission

• To improve health and health care for all Americans through the use of information and technology
HIT Extension Program

United States Regional Extension Centers

*Note: Applicable regions across the nation may also be supported by the Indian Health Board Regional Extension Center, headquartered in Washington DC.
**REC Services & Functions**

**RECs will support and serve health care providers to help them quickly become adept and meaningful users of electronic health records (EHRs).**

**Vendor Selection**
- Assess provider’s health IT needs and selecting/negotiating contracts with vendors or resellers

**Workforce**
- Partner with local resources to help integrate health IT into the initial and ongoing training of health professionals and supporting staff

**Interoperability & HIE**
- Will assist providers in meeting functional interoperability needs such as electronic exchange of laboratory orders & results

**Implementation Support**
- Provide end-to-end project management support over entire EHR implementation process

**Meaningful Use**
- Provide expert assistance to help bring providers to Meaningful Use

**Practice & Workflow Design**
- Assist practices in improvement of daily operations to help achieve Meaningful Use

**Privacy & Security**
- Implement best practices to facilitate the protection of patient information

**Outreach & Education**
- Share knowledge of best practices to select, implement, and meaningfully use certified EHR technology
Federal HIT Strategic Plan

2011 – 2012: Data Capture and Sharing
- Accelerated adoption
- Data capture and exchange

2013 – 2014: Demonstrate Health System Improvement
- Widespread adoption and data exchange
- Process improvement

2015+: Transform Health Care and Population Health through Health IT
- Demonstrated improvements in care, efficiency, and population health
- Breakthrough examples of delivery and payment reform

Beyond 2015: Transformed Health Care
- Enhanced ability to study care delivery and payment systems
- Empowered individuals and increased transparency
- Improved care, efficiency, and population health outcomes

STRATEGIC GOALS

- Achieve Adoption and Information Exchange through Meaningful Use of Health IT
- Improve Care, Improve Population Health, and Reduce Health Care Costs through the Use of Health IT
- Inspire Confidence and Trust in Health IT
- Empower Individuals with Health IT to Improve their Health and the Health Care System
- Achieve Rapid Learning and Technological Advancement

Source: Office of the National Coordinator (ONC)
Is there any doubt about the benefits of technology?
New Orleans 2005
Hurricane Katrina: Pre-EHR
Many New Orleans residents lost their paper medical records in one of the worst Hurricanes in history. Not only do patients not have their medical history but neither do their physicians or hospital.
Joplin 2011
Tornado: Post EMR
The Joplin tornado proved once again the resilience afforded by hospitals and providers transitioning from paper to EMRs. Within six days the hospital was functioning in a temporary facility with access to their medical records.
Meaningful Use is using certified EHR technology to:

- Improve quality, safety, efficiency, and reduce health disparities
- Engage patients and families in their health care
- Improve care coordination
- Improve population and public health
- All the while maintaining privacy and security
### EHR Incentive Program Active Hospital Registrations (March 2012)

<table>
<thead>
<tr>
<th>Hospital Totals</th>
<th>128</th>
<th>3,483</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare Only</td>
<td>4</td>
<td>190</td>
</tr>
<tr>
<td>Medicaid Only</td>
<td>3</td>
<td>78</td>
</tr>
<tr>
<td>Medicare Medicaid</td>
<td>121</td>
<td>3,215</td>
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</table>
### Medicare Payments Through March 2012

<table>
<thead>
<tr>
<th>Eligible Hospital</th>
<th># Hospitals</th>
<th>Total Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Subsection (d)</td>
<td>822</td>
<td>$1,550,727,46</td>
</tr>
<tr>
<td>Critical Access</td>
<td>89</td>
<td>$49,334,143</td>
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<tr>
<td><strong>Total</strong></td>
<td><strong>911</strong></td>
<td><strong>$1,600,061,599</strong></td>
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</tbody>
</table>

**Total Payments**

$3,064,069,772

### Medicaid Payments Through March 2012

<table>
<thead>
<tr>
<th>Eligible Hospital</th>
<th># Hospitals</th>
<th>Total Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute Care (including CAHs)</td>
<td>1,718</td>
<td>$1,355,199,603</td>
</tr>
<tr>
<td>Children’s</td>
<td>38</td>
<td>$108,808,570</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>1,756</strong></td>
<td><strong>$1,464,008,173</strong></td>
</tr>
</tbody>
</table>
## Updated Stage 2 Timeline

<table>
<thead>
<tr>
<th>First Payment Year</th>
<th>Stage of Meaningful Use</th>
</tr>
</thead>
<tbody>
<tr>
<td>2011</td>
<td>1</td>
</tr>
<tr>
<td>2012</td>
<td>1</td>
</tr>
<tr>
<td>2013</td>
<td>1</td>
</tr>
<tr>
<td>2014</td>
<td>1</td>
</tr>
<tr>
<td>2015</td>
<td>1</td>
</tr>
<tr>
<td>2016</td>
<td>1</td>
</tr>
<tr>
<td>2017</td>
<td>1</td>
</tr>
</tbody>
</table>
Proposed Objectives/Measures

- EPs must meet or qualify for an exclusion to 17 core objectives and 3 of 5 menu objectives.
- Eligible hospitals and CAHs must meet or qualify for an exclusion to 16 core objectives and 2 of 4 menu objectives.
- Nearly all of the Stage 1 meaningful use core and menu objectives would be retained for Stage 2 meaningful use.
- The “exchange of key clinical information” core objective from Stage 1 would be re-evaluated in favor of a more robust “transitions of care” core objective in Stage 2.
- “Provide patients with an electronic copy of their health information” objective would be removed because it would be replaced by an electronic/online access” core objective.
- Multiple Stage 1 objectives that would be combined into more unified Stage 2 objectives, with a subsequent rise in the measure threshold that providers must achieve for each objective that has been retained from Stage 1.
Proposed CQM Changes

- EPs, a set of clinical quality measures beginning in 2014 that align with existing quality programs such as measures used for the Physician Quality Reporting System (PQRS), CMS Shared Savings Program, and National Council for Quality Assurance (NCQA) for medical home accreditation, as well as those proposed under Children’s Health Insurance Program Reauthorization Act (CHIPRA) and under ACA Section 2701.

- For eligible hospitals and CAHs, the set of CQMs beginning in 2014 would align with the Hospital Inpatient Quality Reporting (HIQR) and the Joint Commission’s hospital quality measures.

- EPs, eligible hospitals, and CAHs would submit CQM data electronically. Solicitation of public feedback to determine mechanisms for electronic CQM reporting.

- EPs to report 12 CQMs and eligible hospitals and CAHs to report 24 CQMs in total.
Proposed Payment Adjustments

- Payment adjustment would be determined by a prior reporting period, successful meaningful user in 2013 would avoid payment adjustment in 2015.
- Any Medicare provider that first meets meaningful use in 2014 would avoid the penalty if they are able to demonstrate meaningful use at least 3 months prior to the end of the calendar or fiscal year (respectively) and meet the registration and attestation requirement by July 1, 2014 (eligible hospitals) or October 1, 2014 (EPs).
- Three categories of exceptions based on the lack of availability of internet access or barriers to obtaining IT infrastructure, a time-limited exception for newly practicing EPs or new hospitals who would not otherwise be able to avoid payment adjustments, and unforeseen circumstances such as natural disasters that would be handled on a case-by-case basis.
- Solicitation of comments on a fourth category due to a combination of clinical features limiting a provider’s interaction with patients and lack of control over the availability of Certified EHR technology at their practice locations.
Anticipated Changes Stage 1 -2

- Increase in the Health Information Exchange (HIE) requirement with a focus on infrastructure
- The addition of new measures (for example, 30% of electronic notes or 30% EMAR tracking)
- Patient portals will be required
- Increase in the percentage of CPOE requirements
- Increase hospital requirements to 24 critical quality measures (CQM’s)
- The addition of several new measures such as identifying care team members & longitudinal care plans
Proposed Stage 2 Requirements that Could Affect Stage 1 Reporting (2014)

• Proposed measures required for Stage 2 but can be achieved/reported in the continuation of Stage 1
  – Changes to the denominator of computerized provider order entry (CPOE)
  – Changes to the age limitations for vital signs
  – Examples:
    ❖ Hospital A Attested to Stage 1 year one of 90 days of MU prior to Stage 2 Final Rule. Hospital A could elect to increase their CPOE Measure from its Stage 1 Requirement to the Stage 2 Requirement for Stage 1 Year two
    ❖ Hospital B has not yet Attested to Stage 1 year one of MU. They are live and plan to begin their MU 90 Reporting Period sometime after Stage 2 Final Rule is published. Hospital B could elect to increase their CPOE Measure from its Stage 1 Requirement to the Stage 2 Requirement
Proposed Rule Measures Not Effective Until Stage 2

• Proposed measures not in effect until Stage 2

• Elimination of the “exchange of key clinical information” core objective from Stage 1 in favor of a “transitions of care” core objective requiring electronic exchange of summary of care documents in Stage 2

• Replacing “provide patients with an electronic copy of their health information” objective with a “view online, download and transmit” core objective.
Impact on Patient Care: Opportunities

- Improved patient safety and quality of care by focusing on the measures
- Better quality healthcare for an entire community due to the electronic sharing of personal health information (PHI)
- Patient portals allow patients to take a more active and knowledgeable role in their own healthcare
Impact on Patient Care: Challenges

• EHR Vendors may be overburdened due to continued support of facilities in Stage 1 MU and the requirement to support HIE
• The new measures may require EHR software upgrades which could lead to unanticipated technical issues
• Education requirements for new employees for the electronic documentation and processes in Stage 2
To Ensure Success

• An EHR team must be in place - do not leave this task to one individual

• Designate super-users for multiple (preferably every) departments

• Utilize as many “official” resources as possible
  – Current recognized resources and tools will be identified and discussed

• Stay up-to-date on regulatory announcements/requirements-sign up for listserves and bookmark websites
To Ensure Success (cont.’d)

- Use your designated Regional Extension Centers (RECs)- they are a free resource to you

- Network with and ask questions of your vendors, co-workers, colleagues, officials at CMS, ONC, Medicaid, State Reporting Office and Office of eHealth

- Foster an excellent working relationship with your vendor as an ongoing relationship will be necessary for upgrades, updates and ongoing training as requirements change
Best Practices for Adoption

• **Better Preparation** – More than one quarter of hospitals (28 percent) reported to scanning all patient records.

• **Scanning the Right Records** – Records managers can ease the EMR transition by prioritizing which records caregivers need first and most often for scanning.

• **Better Resource Utilization** – Misuse of personnel can be the biggest drain on a scanning budget
Ways to Gain Efficiencies

• Do your EHR research and understand the government requirements

• Invest in training your staff and employ any free training opportunities

• Maintain a positive relationship and foster open communication with your vendor as the Stages and requirements of MU continue to evolve
Ways to Gain Efficiencies (cont.’d)

- Centralize meetings to ensure all departments are using the technology, sharing best practices and identifying improvement opportunities

- Ensure the EHR will have the required interfaces to connect for HIE

- Create a culture that encourages and supports HIT adoption
Barriers to Adoption Exist

According to HIMSS Analytics 2012 Leadership Survey:

• Adequate staffing (Most leaders reported an expected increase to HIT staff over the next year.)

• Competing priorities (ICD-10, Medicare Shared Savings Programs, ACO)

• Expense of software purchases and implementation
  – (For the first time since EMR’s were introduced in the marketplace, expense was NOT the main barrier.)
Competing Priorities

Overlapping Timelines of ICD-10, Meaningful Use of EHRs, and Health Reform Initiatives

Federal Fiscal Year: FY 2010 - FY 2016

**Transition to ICD-10**
- Transition to ICD-10 requires extensive system changes.
- HIPAA enforcement extended four years to complete.
- Requires partial ICD code freeze during transition.

**Administrative Simplification**
- Transition to new version of HIPAA transaction standards (2014), followed by adoption of specifying codes in electronic exchange of claims-related transactions.
- Also involves reduction of Health plan ID and other changes to administration transactions over time.

**Meaningful Use of EHRs**
- The HHS Office of the National Coordinator for Health Information Technology (ONC) will implement incentives tied to the meaningful use of health information technology.
- Stage 1 of meaningful use requirements begins in 2012, with Stage 2 requirements to be released in 2013.

**Health Reform Initiatives**
- Health reform introduced accountable care organizations (ACOs), value-based purchasing, risk adjustment payments, bundled payments, and- payments for hospital-acquired conditions that will require new IT systems to support procedural changes in operations.
- These new program rules may incorporate new or expanded data sets that will need to be maintained based on ICD-10. More of these programs also require development of baseline and early performance metrics using data from prior years.

**HIPAA Privacy Changes**
- The changes in ICD-10 introduced changes to the HIPAA privacy provisions.
- Covered entities will need to review their IT systems to account for a broader range of disclosures of PHI and to provide mechanisms with electronic copies of health information built in electronic forms.
- These data for both programs are unknown, so challenging is ongoing.

**ICD-10 Implementation**
- Required Oct. 1, 2013

Note: The Federal Fiscal Year starts on October 1 of the previous calendar year. For example, FY 2014 starts on October 1, 2013.
Resources

• CMS.Gov Fact Sheet
  https://www.cms.gov/apps/media/press/factsheet.asp?Counter=4286&intNumPerPage=10&chkDate=&checkKey=&srchType=1&numDays=3500&srchOpt=0&srchData=&keywordType=All&chkNewsType=6&intPage=&showAll=&pYear=&year=&desc=&cboOrder=date

• tnREC.org Hospital Tools
  http://www.tnrec.org/tools-resources/improving-healthcare/hospital-tools/

• Agency for Healthcare Research and Quality

• HITECH Answers
  http://www.hitechanswers.net/ehr-adoption-2/meaningful-use/
  http://www.hitechanswers.net/stage-2-meaningful-use-summary-of-major-provisions/

• CMS EHR Incentives FAQ’s

• HHS Stage 2 Request for comment document

• American Hospital Association
  http://www.aha.org/content/11/mu-overlappingtimeline.pdf

http://press.himss.org/article_display.cfm?article_id=5390
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any. questions?