The Stimulus Package (ARRA) and EHR Meaningful Use

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HL7 Child Health Work Group
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Background
Need for HIT Adoption

• We are experiencing a current economic crisis that is fueled by a broken healthcare system with significant variation in quality of care, patient safety shortfalls, inefficiency, and waste

• Current, paper-based health information process “wastes hundreds of billions of dollars annually” (Halamaka, Levitt, Tooker, 2009)

• There is strong evidence of low physician and hospital adoption of qualified or comprehensive HIT

• HIT developers have failed to incorporate clinical thought flow or work flow into HIT design
  – “Health IT fails to make the day easier for nurses and doctors” (Ball, 2008)
  – “IT systems are built without listening to the end users”
Adoption of Clinical IT in Hospitals is Low and Even Lower Among Physicians

- According to the 2008 KLAS CPOE Digest, 9.6 percent of hospitals are “doing some level of CPOE,” up from 6.8 in 2007 and 3.5 in 2003 (2008 KLAS CPOE Digest, February 2008)

- The latest data from HIMSS Analytics suggests that just over 40 percent of hospitals have basic clinical (nursing) documentation but less than 2 percent have physician documentation (HIMSS Analytics, 2009)
Overview of ARRA Major Healthcare Provisions

- The legislation includes roughly $36-45 billion in spending on Medicare and Medicaid incentives for the “Meaningful Use” of certified electronic health records (EHRs)
  - The provisions are designed to create a use incentive, not a purchase incentive
  - The $36-$45 billion estimate relies on two aggressive assumptions:
    • 90 percent of physicians and 70 percent of hospitals will be “Meaningful Users” by 2019
    • Increased adoption of health IT (HIT) will save the government $15 – $16 billion
- The Office of the National Coordinator (ONC) has received elevated status and budget ($2 billion)
  - The timelines for developing and approving standards are aggressive
  - New programs provide both financial assistance and implementation guidance/expertise
  - First RFPs Issued August 2009
    • $564 for HIE funding at/ to state level ($7 Million Avg ($4-40))
    • $598 for regional extension centers to non profits ( $8.5 Million Avg)
- $1.1 billion to study comparative effectiveness
  - Research funds go to the Agency for Healthcare Research and Quality (AHRQ), the National Institutes of Health (NIH), and the U.S. Department of Health and Human Services (HHS)
- Health Insurance Assistance for the Unemployed
  - COBRA premium assistance for unemployed workers
  - Expanded matching funds for state Medicaid programs
    • 6.2 percentage point increase in Medicaid FMAP amounts
    • Intended to help states handle expected beneficiary increases due to rising unemployment rate
Financial Incentives Overview

The HITECH Act includes incentives for the “Meaningful Use” of certified systems; it is not a purchase incentive.

- **Medicare EHR incentives**
  - Individual physicians are eligible for incentive payments of 75 percent of their Medicare charges up to a total of $44,000 over five years.
  - Medicare EHR incentive payments to hospitals are based on discharge volume and the hospital’s percentage of Medicare patients.
  - First payment year is 2011; penalties for non-use start in 2015.

- **Medicaid EHR incentives**
  - Requires that individual provider or hospital have a minimum Medicaid patient volume.
  - Individual providers receiving Medicaid EHR incentives waive any right to Medicare EHR incentive payments; hospitals are eligible for both.
  - Incentives for individual providers are based on costs for EHR software, implementation and maintenance.
  - Medicaid EHR incentives for hospitals are calculated in a similar fashion to Medicare incentives, but are based on a hospital’s percentage of Medicaid patients.
  - No penalties for non-use.
Financial Incentives Overview

The terms “Certified System” and “Meaningful Use” are not clearly defined.

- **Certified EHRs must:**
  - Include patient demographic and clinical health information, such as medical history
  - Have the “capacity” to:
    - Provide clinical decision support
    - Support computerized physician order entry (CPOE)
    - Capture and query information relevant to healthcare quality
    - Exchange electronic health information with, and integrate such information from other sources
  - We believe that the minimum requirements for a certified system will be those in the current Certification Commission for Health Information Technology (CCHIT) certification

- **“Meaningful Use” is defined as:**
  - “Using the product in a meaningful manner”
    - For individual ambulatory providers, this explicitly includes use of e-prescribing capabilities
    - For hospitals, the law states that requirements will become more stringent over time
  - For both hospitals and individual ambulatory physicians, "Meaningful Use" includes:
    - Using the EHR to report on designated clinical quality measures
    - Demonstrating that the product is connected in a way that allows health information exchange
Incentives for Hospitals

Hospitals are eligible for both Medicare and Medicaid EHR incentives; penalties for non-use begin in 2015.

• Medicare EHR incentive payments are paid over four years
  – The base Medicare EHR incentive, an amount that varies based on discharge volume and the hospital’s percentage of Medicare patients, is paid in full the first payment year
  – A decreasing fraction of the base incentive is paid in years two, three, and four
  – Medicare EHR incentives phase out starting in 2014

• Hospitals with greater than 10 percent Medicaid patient volume (as well as children’s hospitals with any Medicaid volume) are also eligible for Medicaid incentive payments
  – Calculated similarly to Medicare hospital EHR incentives, but based on the hospital’s percentage of Medicaid patients
  – Unlike Medicare EHR incentives, “Meaningful Use” does not have to be demonstrated until second payment year
  – HHS Secretary shall establish the overall hospital EHR amounts for each Medicaid provider

• Hospitals that do not demonstrate meaningful EHR use prior to 2015 will be subject to Medicare market basket reductions

Hospital base incentive (Medicare) = $2,000,000 + $200 per discharge for discharges 1,150 to 23,000

\[ \text{the hospital's percentage of Medicare patients (with an adjustment for charity)} \]

<table>
<thead>
<tr>
<th>Medicare EHR Payment Year</th>
<th>Actual Payment Amount to Hospital</th>
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<tbody>
<tr>
<td>Year 1</td>
<td>100% of base incentive</td>
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<tr>
<td>Year 2</td>
<td>75% of base incentive</td>
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<tr>
<td>Year 3</td>
<td>50% of base incentive</td>
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<tr>
<td>Year 4</td>
<td>25% of base incentive</td>
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<thead>
<tr>
<th>Year</th>
<th>Reduction in Market Basket for Hospitals Without an EHR¹</th>
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<tbody>
<tr>
<td>2015</td>
<td>33.3%</td>
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<tr>
<td>2016</td>
<td>66.6%</td>
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<tr>
<td>2017</td>
<td>100%</td>
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<tr>
<td>2018</td>
<td>100%</td>
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¹ Reduction in market basket applies to ¾ of the amount the hospital would otherwise be eligible for.
Incentives for Hospitals

The example hospital below would be eligible for up to $4,265,270 in Medicare incentive payments if meaningful EHR use was demonstrated prior to 2014.

Example Hospital

- Beds: 276
- Total discharges: 19,453
- Medicare patient volume: 29 percent
- Medicaid patient volume: 12 percent
- Percent of total charges for charity care: 3.6 percent

<table>
<thead>
<tr>
<th>First Year of Meaningful EHR Use</th>
<th>Medicare Incentive Payment/Adjustment to Market Basket Update</th>
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<tbody>
<tr>
<td>2011</td>
<td>$1,706,108</td>
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<tr>
<td>2012</td>
<td>$0</td>
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<td>2013</td>
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<tr>
<td>2019</td>
<td>$0</td>
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Incentives for Hospitals

State-awarded Medicaid incentives for the example hospital would total $1,787,622.

Example Hospital

- Beds: 276
- Total discharges: 19,453
- Medicare patient volume: 29 percent
- Medicaid patient volume: 12 percent
- Percent of total charges for charity care: 3.6 percent

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<thead>
<tr>
<th>First Year of Meaningful EHR Use</th>
<th>Maximum Medicaid Incentive Payment Available from State</th>
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<tbody>
<tr>
<td>2011</td>
<td>$893,811</td>
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<tr>
<td>2012</td>
<td>$893,811</td>
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<td>2013</td>
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<td>2017</td>
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<td>2018</td>
<td>$0</td>
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Assumes fastest possible payout of Medicaid incentive by state (50 percent in first year, 40 percent in second year, 10 percent in third year)

Note: To receive Medicaid EHR incentive payments, “Meaningful Use” does not need to be demonstrated until payment year 2. A qualified provider must only demonstrate that “it is engaged in efforts to adopt, implement, or upgrade certified EHR technology” during the first payment year.
Medicare EHR Use Incentive Payments

*Individual physicians are eligible for as much as $44,000 in Medicare HER use incentive payments, but the timeline is aggressive.*

- Incentives are based on 75 percent of the physician’s allowable charges to Medicare Part B in a given payment year, up to the amounts detailed in the table below
  - Individual physicians that demonstrate meaningful EHR use in 2011 or 2012 are eligible for up to $44,000 in total incentive payments; this drops down to $39,000 for EHR adoption in 2013 and $24,000 for adoption in 2014
  - Note: For physicians in designated health professional shortage areas, the incentive payment is 10 percent higher

- Incentives phase out fairly quickly.
  - No incentive payments will be made after 2016
  - Individual physicians who do not demonstrate meaningful EHR use until 2014 will only be eligible for payment years 2, 3, and 4

- Individual physicians who have not demonstrated meaningful use of an EHR by 2015 will subject to reductions in Medicare pay
  - If EHR adoption is less than 75 percent in 2018 or 2019, the penalty increases one percentage point from the previous year, but the overall penalty cannot exceed 5 percent

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<tr>
<th>Payment Year</th>
<th>Maximum Payment</th>
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<tr>
<td>1</td>
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<tr>
<td>2</td>
<td>$12,000</td>
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<tr>
<td>3</td>
<td>$8,000</td>
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<tr>
<td>4</td>
<td>$4,000</td>
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<tr>
<td>5</td>
<td>$2,000</td>
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<table>
<thead>
<tr>
<th>Year</th>
<th>Medicare Penalty</th>
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<tbody>
<tr>
<td>2015</td>
<td>1%</td>
</tr>
<tr>
<td>2016</td>
<td>2%</td>
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<tr>
<td>2017</td>
<td>3%</td>
</tr>
<tr>
<td>2018</td>
<td>3 – 4%*</td>
</tr>
<tr>
<td>2019</td>
<td>3 – 5%*</td>
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* $18,000 is for meaningful EHR use in 2011 or 2012; $15,000 if first payment year is 2013.
Maximum Medicare EHR Meaningful Use Incentive Payments

The chart below outlines the maximum Medicare EHR incentive payments for meaningful use available to an individual physician.

- Actual amounts will depend on amount of services furnished under Medicare Part B
- Physicians in designated health professional shortage areas are eligible to receive an additional 10 percent of the amounts below

<table>
<thead>
<tr>
<th>First Year of Meaningful EHR Use</th>
<th>Maximum Medicare Incentive Payment/Percent Reduction in Medicare Pay</th>
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<tbody>
<tr>
<td>2011</td>
<td>$18,000</td>
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<tr>
<td>2012</td>
<td>$0</td>
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<tr>
<td>2013</td>
<td>$0</td>
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<td>2019</td>
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<tr>
<td>2020</td>
<td>$0</td>
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</table>
Medicare EHR Meaningful Use Incentive Payments

Individual providers with high Medicaid patient volumes can alternatively choose to receive Medicaid EHR incentive payments — but they cannot receive both Medicare and Medicaid EHR incentives.

• The provider must have Medicaid patient volume of greater than 30 percent in order to qualify for individual Medicaid incentive payments
  – Applies to non-hospital based physicians, nurse practitioners, and certified nurse midwives are also eligible for Medicaid EHR incentives
  – Non-hospital based pediatricians with Medicaid patient volume between 20 and 30 percent are eligible for two-thirds of incentive payment amount

• Participating providers are eligible for a payment equal to 85 percent of their net “allowable costs” for an EHR

• To be eligible for the first Medicaid EHR incentive payment year, a qualified provider must only demonstrate that “it is engaged in efforts to adopt, implement, or upgrade certified EHR technology”
  – Meaningful use must be demonstrated to receive incentives in subsequent years

“Allowable Costs”
• Total costs for purchase and implementation of EHR (including hardware, software, and services) cannot exceed $25,000 or include costs over a period of 5 years

• Annual allowable costs not associated with the initial EHR purchase/implementation (such as maintenance) cannot exceed $10,000 per year or exceed a period of greater than 5 years

• Maximum aggregate allowable amount is $75,000 per provider ($25,000 up front + $10,000 annually over five years) — or $63,750 with 85 percent adjustment
Incentive Payment

An IDN would calculate its total incentive payment based on the amount available to each individual hospital and each eligible ambulatory provider.

- Only “subsection (d) hospitals” are eligible for Medicare EHR incentives
  - This excludes psychiatric, rehabilitation, and long-term care hospitals, as well as certain cancer centers
- The legislation is not clear on whether hospital-based physicians who provide routine ambulatory care are eligible for individual incentive payments
  - The legislation states only that the provider cannot be “hospital-based”
    - Hospital based providers are those who furnish “substantially all” of their “services in a hospital setting (whether inpatient or outpatient) and through the use of facilities and equipment, including qualified electronic health records, of the hospital”
    - The determination of who is a hospital-based eligible professional “shall be made on the basis of the site of service (as defined by the Secretary) and without regard to any employment or billing arrangement between the eligible professional and any other provider"
- We are trying to clarify with CMS
Privacy Requirements

The stimulus bill includes new privacy requirements for covered entities and expands accountability for data breaches.

- **Covered entities must notify individuals of privacy breaches within 60 days**
  - Organizations can notify affected individuals by mail or email
  - Organizations must notify HHS and prominent media outlets for breaches that affect more than 500 individuals
  - Takes effect 30 days after final regulations are published (which must occur within 180 days of enactment)

- **Covered entities must limit the use, disclosure, and requesting of personal health information to the minimum needed for authorized purposes**

- **Individuals have a right to an accounting of all protected health information (PHI) disclosures from the past three years**
  - This includes disclosures related to payments, treatments, and operations
  - Current EHR users have until 2014 to comply; later adopters must comply by 2011 or when it acquires an EHR

- **HIPAA privacy provisions and breach requirements now also apply to business associates of covered entities**
  - New requirements also apply to personal health record (PHR) vendors, service providers, RHIOs, and HIEs
  - Takes effect 30 days after final regulations are published (which must occur within 180 days of enactment)

- **Allows criminal and civil penalties to apply to individuals**
  - New criminal penalties take effect in 24 months, subject to final regulations promulgated by the HHS Secretary
  - New civil monetary penalties take effect immediately
“EHR Meaningful Use”
What Does the Law Mean by “EHR Meaningful Use”? 

- The language in the bill does not specifically provide a description for “meaningful use,” but it does state that:
  - The physician must use “certified EHR technology” in a “meaningful” manner, including electronic prescribing
  - The certified EHR technology is connected in a manner that provides for the electronic exchange of health information to improve the quality of health care, such as promoting care coordination
  - The physician must submit information on clinical quality measures specified by HHS

- HIT Policy Committees Refine “Meaningful Use” Criteria
  - Latest Definition as of July 16 2009
  - Final Definition Late December 2009
  - CMS Measurement and Payment Definition Late December 2009
EHR Committee Meaningful Use Philosophy Bending the Curve Towards Transformed Health
Achieving Meaningful Use of Health Data
HIT-Enabled Health Reform
Achieving Meaningful Use

- **2009**: HITECH Policies
- **2011**: 2011 Meaningful Use Criteria (Capture/share data)
- **2013**: 2013 Meaningful Use Criteria (Advanced care processes with decision support)
- **2015**: 2015 Meaningful Use Criteria (Improved Outcomes)
Phasing of MU Criteria
Some Considerations

• Enable health reform
• Focus on health outcomes, not software

Feasibility
– Balance urgency of health reform with calendar time needed to implement HIT
– Starting from low adoption rate
– Sensitive to under-resourced practices (e.g., small practices, community health centers, rural settings)
– But also, HIT essential to achieving health reform in all settings

• Recovery Act provisions
– Timelines fixed (2015, 2011 – 12)
– Funding rules defined (front-loaded incentives)
HIT Committee Workgroup Meaningful Use Framework

• Workgroup’s framework placed a deliberate focus on improved health outcomes and efficiency demonstrated through meaningful use of HIT

• Parsimonious set of key objectives and exemplar measures to “exercise” the capabilities of the EHR and the effectiveness of its use

• Demonstrating the capability of reporting on MU measures and continuously improving its score would provide evidence of the organization’s ability to use HIT to achieve goals of a transformed health system

• Initial MU Criteria June 2009 with feedback and New MU Criteria July 2009

• Final MU Criteria December 2009
Improve Quality, Safety, Efficiency; Reduce Disparities
Timing Feedback

• “You want it when?”

• 2011 is only 18 months away
  – Reminder that 2012 start date (up to 42 months) qualifies for full incentive potential (CMS will set measurement period rules)

• If an organization cannot meet 2012, the 2013 criteria sets an even higher bar (“rising tide”)
  – Work group recommends use of “adoption year” timeframe (e.g., “2011 measures” applies to first adoption year (even if HIT adopted in 2013); “2013 measures” applies to third adoption year)
Timing
Feedback (cont’d)

• CPOE too fast (primarily hospitals)
  – Unintended consequence of trying to implement faster than feasible, considering workflow redesign pre-work
  – Establish 10% threshold of CPOE orders for hospitals
    • Accommodates pilots, implementations in-progress

• Start clinical decision support earlier
  – It’s the payoff (faster)
  – Need to implement EHR before turning on rules; also need to populate the database (slower)
  – Start with one rule; make it important: “Implement one clinical decision rule relevant to high clinical priority”
EHR Meaningful Use

Improve Care Coordination
Feedback

• Need better outcomes measures for care coordination
  – NQF has a call for measures in care coordination (NPP priority)
  – Propose 2013 measure of 10% reduction in 30-day readmission compared to 2012
  – Improvement in NQF-endorsed measures of care coordination

• How to meet health information exchange in 2011 when HIE organizations do not currently exist or do not connect all clinical trading partners
  – 2015 should include required participation in nationwide HIE
  – Require capability and exchange where possible in 2011
  – Defer to HIE workgroup for specific requirements and roadmap

Patient and Family Engagement
Feedback

• Provide access to electronic health information (in addition to electronic copy)
  – Included in 2011
  – Moved up real-time access to patient information in PHR from 2015 to 2013
Privacy and Security
Feedback

• Clarify “under investigation;” could any complaint trigger “investigation”?
  – Length of investigation could also potentially cause a missed payment (even if found “not guilty”)
  – Intent was to disallow participation in HIT incentives if confirmed HIPAA violation goes unresolved
  – Revised wording: “… recommend that CMS withhold meaningful use payment for any entity until any confirmed HIPAA privacy or security violation has been resolved”

• How can federal program “enforce” compliance with state privacy laws?
  – Shift to Medicaid section: “… recommend that state Medicaid administrators withhold meaningful use payment for any entity until any confirmed state privacy or security violation has been resolved”
Summary of Feedback for HIT Committee MU Criteria

- Strong public and industry endorsement of outcomes-focused framework for meaningful use
- Although a clear stretch, meaningful use of HIT is critical to the president’s and congress’s agenda for health reform, which drives the urgency of the timelines
- Achieving the aggressive timelines will require more than financial incentives (e.g., education, regional extension centers, increased informatics workforce, product improvements, accelerated technical standards adoption)
- While extremely ambitious, with robust alignment of incentives, the vision is achievable
## Health Outcomes Policy

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<tbody>
<tr>
<td></td>
<td></td>
<td>Goal is to electronically capture in coded format and to report health information and to use that information to track key clinical conditions</td>
<td>Report quality measures to CMS including:</td>
<td>Use CPOE for all order types</td>
<td>Use CPOE for all orders</td>
<td>Additional quality reports using HIT-enabled NQF-endorsed quality measures [EP, IP]</td>
<td>Achieve minimal levels of performance on quality, safety, and efficiency measures</td>
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<td></td>
<td></td>
<td></td>
<td>- o % diabetics with A1c under control [EP]</td>
<td>Use evidence-based order sets</td>
<td>Use evidence-based order sets</td>
<td>Implement clinical decision support for national high priority conditions</td>
<td>Clinical outcome measures (TBD) [OP, IP]</td>
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<td>- o % hypertensive patients with BP under control [EP]</td>
<td>Manage chronic conditions using patient lists and decision support</td>
<td>Manage chronic conditions using patient lists and decision support</td>
<td>Medical device inter-operability</td>
<td>Efficiency measures (TBD) [OP, IP]</td>
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<td>- o % of patients with LDL under control [EP]</td>
<td>Provide clinical decision support at the point of care (e.g., reminders, alerts)</td>
<td>Provide clinical decision support at the point of care (e.g., reminders, alerts)</td>
<td>Multimedia support (e.g., x-rays)</td>
<td>Safety measures (TBD) [OP, IP]</td>
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<td>- o % of smokers offered smoking cessation counseling [EP, IP]</td>
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<td>Improve quality, safety, efficiency, and reduce health disparities</td>
<td>• Provide access to comprehensive patient health data for patient’s healthcare team</td>
<td>• Use CPOE for all orders</td>
<td>• Implement drug-drug, drug-allergy, drug-formulary checks</td>
<td>• Maintain an up-to-date problem list of current and active diagnoses based on ICD-9 or SNOMED</td>
<td>• Use CPOE for all orders</td>
<td>• Provide access to comprehensive patient health data for patient’s healthcare team</td>
<td>• Implement drug-drug, drug-allergy, drug-formulary checks</td>
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<td></td>
<td>• Use evidence-based order sets and CPOE</td>
<td>• Implement drug-drug, drug-allergy, drug-formulary checks</td>
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<td>• Implement drug-drug, drug-allergy, drug-formulary checks</td>
<td>• Implement drug-drug, drug-allergy, drug-formulary checks</td>
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<tr>
<td></td>
<td>• Apply clinical decision support at the point of care</td>
<td>• Generate and transmit permissible prescriptions electronically (eRx)</td>
<td>• Implement drug-drug, drug-allergy, drug-formulary checks</td>
<td>• Maintain an up-to-date problem list of current and active diagnoses based on ICD-9 or SNOMED</td>
<td>• Provide clinical decision support at the point of care (e.g., reminders, alerts)</td>
<td>• Generate and transmit permissible prescriptions electronically (eRx)</td>
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# Health Outcomes Policy (cont’d)

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<tr>
<td></td>
<td></td>
<td>Goal is to electronically capture in coded format and to report health information and to use that information to track key clinical conditions</td>
<td>Maintain active medication list</td>
<td>% of patients with recorded BMI [EP]</td>
<td>% of patients with recorded BMI [EP]</td>
<td>% of patients with recorded BMI [EP]</td>
<td>Other efficiency measures (TBD) [EP, IP]</td>
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<td>Maintain active medication allergy list</td>
<td>Maintain active medication allergy list</td>
<td>% eligible surgical patients who receive VTE prophylaxis [IP]</td>
<td>% eligible surgical patients who receive VTE prophylaxis [IP]</td>
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<td>Record demographics:</td>
<td>Record demographics:</td>
<td>% of orders (for medications, lab tests, procedures, radiology, and referrals) entered directly by physicians through CPOE</td>
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<td>– preferred language</td>
<td>– preferred language</td>
<td>Use of high-risk medications (Re: Beers criteria) in the elderly</td>
<td>Use of high-risk medications (Re: Beers criteria) in the elderly</td>
<td>Use of high-risk medications (Re: Beers criteria) in the elderly</td>
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<td>– insurance type</td>
<td>– insurance type</td>
<td>% of patients over 50 with annual colorectal cancer screenings [EP]</td>
<td>% of patients over 50 with annual colorectal cancer screenings [EP]</td>
<td>% of patients over 50 with annual colorectal cancer screenings [EP]</td>
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<td>– gender</td>
<td>– gender</td>
<td>• Generate lists of patients who need care and use them to reach out to patients (e.g., Reminders care instructions, etc.)</td>
<td>• Generate lists of patients who need care and use them to reach out to patients (e.g., Reminders care instructions, etc.)</td>
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<td>– race</td>
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<td>• Report to patient registries for quality improvement, public reporting, etc.</td>
<td>• Report to patient registries for quality improvement, public reporting, etc.</td>
<td>• Report to patient registries for quality improvement, public reporting, etc.</td>
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<td>– ethnicity</td>
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<td>• Maintain active medication list</td>
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<td>Record advance directives</td>
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<td>Maintain active medication allergy list</td>
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<td>Record vital signs:</td>
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<td>Record demographics:</td>
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## Health Outcomes Policy (cont’d)

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<td>Goal is to electronically capture in coded format and to report health information and to use that information to track key clinical conditions</td>
<td>Record smoking status</td>
<td>% of females over 50 receiving annual mammogram [EP]</td>
<td>% patients at high-risk for cardiac events on aspirin prophylaxis [EP]</td>
<td>% of patients who received flu vaccine [EP]</td>
<td>% lab results incorporated into EHR in coded format [EP, IP]</td>
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<td>Incorporate lab-test results into EHR as structured data</td>
<td>% patients at high-risk for cardiac events on aspirin prophylaxis [EP]</td>
<td>% of patients who received flu vaccine [EP]</td>
<td>% lab results incorporated into EHR in coded format [EP, IP]</td>
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<td>Generate lists of patients by specific conditions to use for quality improvement, reduction of disparities, and outreach</td>
<td>Generate lists of patients by specific conditions</td>
<td>Generate lists of patients by specific conditions</td>
<td>Generate lists of patients by specific conditions</td>
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<td>Send reminders to patients per patient preference for preventive/ follow up care</td>
<td>Implement one clinical decision rule related to a high priority hospital condition</td>
<td>Implement one clinical decision rule related to a high priority hospital condition</td>
<td>Implement one clinical decision rule related to a high priority hospital condition</td>
<td>Implement one clinical decision rule related to a high priority hospital condition</td>
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<td>Eligible Providers</td>
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<td>Goal is to electronically capture in coded format and to report health information and to use that information to track key clinical conditions</td>
<td>Goal is to electronically capture in coded format and to report health information and to use that information to track key clinical conditions</td>
<td>Goal is to achieve and improve performance and support care processes and on key health system outcomes</td>
<td>Goal is to achieve and improve performance and support care processes and on key health system outcomes</td>
<td>Goal is to achieve and improve performance and support care processes and on key health system outcomes</td>
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<td>Eligible Providers</td>
<td>Hospitals</td>
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<tr>
<td>• Document a progress note for each encounter</td>
<td>• Check insurance eligibility electronically from public and private payers, where possible</td>
<td>• Stratify reports by gender, insurance type, primary language, race, ethnicity [EP, IP]</td>
<td>• % of all medications, entered into EHR as generic, when generic options exist in the relevant drug class [EP, IP]</td>
<td>• % of orders for high-cost imaging services with specific structured indications recorded [EP, IP]</td>
<td>• % claims submitted electronically to all payers [EP, IP]</td>
<td>• % patient encounters with insurance eligibility confirmed [EP, IP]</td>
<td>• % patient encounters with insurance eligibility confirmed [EP, IP]</td>
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### Health Outcomes Policy (cont’d)

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<tr>
<td>Eligible Providers</td>
<td>Hospitals</td>
<td>Goal is to electronically capture in coded format and to report health information and to use that information to track key clinical conditions</td>
<td>% of all patients with access to personal health information (including lab results, problem list, medication lists, allergies, discharge summary, procedures), upon request (^1)</td>
<td>Access for all patients to PHR populated in real time with health information</td>
<td>Access for all patients to PHR populated in real time with patient health data</td>
<td>% of patients with full access to PHR populated in real time with EHR data [OP, IP]</td>
<td>Patients have access to self-management tools, related to patient and family engagement [OP, IP]</td>
</tr>
<tr>
<td>Patient Engagement</td>
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<tr>
<td>Provide patients and families with timely access to data, knowledge, and tools to make informed decisions and to manage their health</td>
<td>Provide patients with an electronic copy of their health information (including lab results, problem list, medication lists, allergies) upon request (^1)</td>
<td>Provide patients with an electronic copy of their health information</td>
<td>% of all patients with access to personal health information electronically [EP, IP]</td>
<td>% of all patients with access to PHR populated in real time with health data</td>
<td>% of patients with full access to PHR populated in real time with EHR data [OP, IP]</td>
<td>NPP quality measures, related to patient and family engagement [OP, IP]</td>
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<td>Goal is to electronically capture in coded format and to report health information and to use that information to track key clinical conditions</td>
<td>provide access to patient-specific educational resources</td>
<td>% of encounters for which clinical summaries were provided</td>
<td>% of patients with access to secure patient messaging</td>
<td>% of educational content in common primary languages</td>
<td>% of all patients with preferences recorded</td>
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<tr>
<td>Eligible Providers</td>
<td>Hospitals</td>
<td>% of encounters for which clinical summaries were provided</td>
<td>% of patients with access to patient-specific educational resources</td>
<td>% of all patients with preferences recorded</td>
<td>% of educational content in common primary languages</td>
<td>% of transitions where summary care record is shared</td>
<td>Implemented ability to incorporate data uploaded from home monitoring devices</td>
</tr>
<tr>
<td>• Provide patients with timely electronic access to their health information (including lab results, problem list, medication lists, allergies) 4</td>
<td>• Provide patients with an electronic copy of their discharge instructions and procedures at time of discharge, upon request 4</td>
<td>• Provide access to patient-specific educational resources</td>
<td>• Provide access to patient-specific educational resources in common primary language</td>
<td>• Record patient preferences (e.g., preferred communication media, advance directive, healthcare proxies, treatment options)</td>
<td>• Record patient preferences (e.g., preferred communication media, advance directive, healthcare proxies, treatment options)</td>
<td>• Documentation of family medical history, in compliance with GINA</td>
<td>• Implemented ability to incorporate data uploaded from home monitoring devices</td>
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# Health Outcomes Policy (cont’d)

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<tr>
<td>Improve care coordination</td>
<td>• Exchange meaningful clinical information among professional health care team</td>
<td>• Capability to exchange key clinical information (e.g., problem list, medication list, allergies, test results), among providers of care and patient authorized entities electronically⁸</td>
<td>• Report 30-day readmission rate [IP]</td>
<td>• Retrieve and act on electronic prescription fill data</td>
<td>• Retrieve and act on electronic prescription fill data</td>
<td>• Access to comprehensive patient data from all available sources</td>
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<td>• Capability to exchange key clinical information (e.g., discharge summary, procedures, problem list, medication list, allergies, test results), among providers of care and patient authorized entities electronically⁸</td>
<td>• % of encounters where med reconciliation was performed [EP, IP]</td>
<td>• Produce and share an electronic summary care record for every transition in care (place of service, consults, discharge)</td>
<td>• Produce and share an electronic summary care record for every transition in care (place of service, consults, discharge)</td>
<td>• 10 % reduction in 30-day readmission rates for 2013 compared to 2012</td>
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<td></td>
<td>• Perform medication reconciliation at relevant encounters and each transition of care⁹</td>
<td>• Implemented ability to exchange health information with external clinical entity (specifically labs, care summary and medication lists) [EP, IP]</td>
<td>• Perform medication reconciliation at each transition of care from one health care setting to another</td>
<td>• Perform medication reconciliation at each transition of care from one health care setting to another</td>
<td>• Improvement in NQF-endorsed Care Coordination Measures (TBD)</td>
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⁸ Electronic notification

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## EHR Meaningful Use

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<tbody>
<tr>
<td>Improve population and public health</td>
<td>• Communicate with public health agencies</td>
<td>• Capability to submit electronic data to immunization registries and actual submission where required and accepted. (^7)</td>
<td>• Capability to submit electronic data to immunization registries and actual submission where required and accepted. (^7)</td>
<td>• Report-up-to-date status for childhood immunizations ([EP]^7)</td>
<td>•% reportable lab results submitted electronically ([IP])</td>
<td>• Receive immunization histories and from immunization registries ([EP]^7)</td>
<td>•% of patients for whom an assessment of immunization need and status has been completed during the visit ([EP]^7)</td>
</tr>
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<td>• Capability to provide electronic syndromic surveillance data to public health agencies and actual transmission according to applicable law and practice</td>
<td>• Capability to provide electronic syndemic surveillance data to public health agencies and actual transmission where it can be received</td>
<td>• Capability to provide electronic syndromic surveillance data to public health agencies and actual transmission according to applicable law and practice</td>
<td>• Receive health alerts from public health agencies</td>
<td>• Provide sufficiently anonymized electronic syndrome surveillance data to public health agencies with capacity to link to personal identifiers</td>
<td>• Receive health alerts from public health agencies</td>
<td>• % of patients for whom a public health alert should have triggered and audit evidence that a trigger appeared during the encounter triggered and audit evidence that a trigger appeared during the encounter</td>
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<td></td>
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<td>• Capability to provide electronic syndromic surveillance data to public health agencies and actual transmission according to applicable law and practice</td>
<td></td>
<td>• Provide sufficiently anonymized electronic syndrome surveillance data to public health agencies with capacity to link to personal identifiers</td>
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### Health Outcomes Policy (cont’d)

|--------------------------------|------------------------------------------------------------------------------------------------------|----------------|------------------------------------------------------------------------------------------------------|----------------|------------------------------------------------------------------------------------------------------|----------------|------------------------------------------------------------------------------------------------------|
| Ensure adequate privacy and security protections for personal health information | • 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 | 2011 Objectives: Goal is to electronically capture in coded format and to report health information and to use that information to track key clinical conditions | 2011 Measures: Compliance with HIPAA Privacy and Security Rules  
• Compliance with fair data sharing practices set forth in the Nationwide Privacy and Security Framework | 2013 Objectives: Goal is to electronically capture in coded format and to report health information and to use that information to track key clinical conditions | 2013 Measures: Use summarized or de-identified data when reporting data for population health purposes (e.g., public health, quality reporting, and research), where appropriate, so that important information is available with minimal privacy risk | 2015 Objectives: Goal is to achieve and improve performance and support care processes and on key health system outcomes | 2015 Measures: Provide summarized or de-identified data when reporting data for health purposes (e.g., public health, quality reporting, and research), where appropriate, so that important information is available with minimal privacy risk |
Meaningful Use and Its Impact on Health Information Exchange
Meaningful Use and Its Impact on HIE

Benefits of Participation in HIE

• **Reduced administrative costs associated with manual data entry and paper-based systems**
  – Decreases resource requirements to enter, store, maintain and retrieve paper-based records
  – Decreases payer administrative costs associated with changes in plan coverage with more timely information; including during an encounter (vs. denial, investigation and later approval of coverage in some cases)

• **Reduced costs related to improved access to information**
  – Decreases redundant testing (lab, radiology, other diagnostic)
  – Avoid unnecessary hospitalizations due to missing information (one study estimated 1/7 of hospital visits)
  – More efficient visits (including pre-visit and follow-up)
  – Improves coordination of care with more timely/accurate information across providers (PCP, specialists, etc.)

• **Path to earning stimulus incentives for “meaningful use”**
  – Cost sharing and technical assistance among participants
  – Greater opportunity to earn federal funding to develop the capability

• **Alignment across payers for P4P incentives**
  – Improves reporting capabilities and requirements for quality and outcomes reporting (in alignment with CMS requirements expected under meaningful use)
  – Streamlines data collection and reporting for payers and providers alike

• **More effective medication reconciliation**
  – Reduces risk of severe adverse drug events (ADEs)
  – Improves accuracy and record-keeping of medication history
  – Required by JCAHO

*Note: Industry benefit estimates vary for each benefit category; however, the categories have been relatively consistent for the past five years.*
The State of Health Information Exchange Today

- Health reform goals of higher-quality, more affordable care will not be met without broader and deeper information exchange across the entire health delivery system

- The current state of health information exchange today is spotty and piecemeal
  - The vast majority occurs in a narrow set of transaction silos, such as labs and medication prescriptions, and even here, penetration is very low (4% of eligible prescriptions and 12% of office-based prescribers, for example)
  - Direct exchange of data between EHRs and exchange through organized state/regional health information exchange entities also occurs, but penetration is extremely low and highly variable across implementations
  - Electronic reporting for public and population health measurement and improvement is almost non-existent in the market today

- Health information exchange occurs in the market today, but penetration is very low and non-uniform
Barriers that prevent the market from moving forward

- **The main barriers to health information exchange today are:**
  - Too much uncertainty about legal issues
  - Too little business and clinical imperative to exchange more information
  - Too much technical and organizational difficulty of setting up and maintaining business- and clinically-relevant electronic exchange

- **Getting over these barriers will require:**
  - Incentives and/or penalties to help increase business demand for exchange and encourage a plurality of exchange architectures that are cost-effective and sustainable
  - Actionable standards
  - Monitoring and enforcement mechanisms to ensure adherence to standards

There are many barriers to health information exchange today, and there is thus no single solution to getting more exchange.
Implemented Judiciously, ARRA Funding Can Help Create a Value Proposition for Health Exchange

Need to either lower the technical, organization, and/or legal costs ... AND/OR ... raise the clinical and business imperative for more exchange

Costs
- Technical
- Organizational
- Legal
- Privacy
- Security

Benefits
- Clinical
- Business

Certification, grants to states, RHITECs, and NHIN governance authority can all help to lower the difficulty of health exchange ...

... whereas incentive payments (and penalties) tied to Meaningful Use can create a business imperative for more information exchange
Of All of the Tools Provided by ARRA, MU Incentives are the Most Powerful Lever of Change

- Of the various levers available to the government, Meaningful Use criteria are by far the most influential
  - ~$45B in incentives versus ~2B in discretionary ONC programs
  - Directly affects the value proposition at the point of purchase
- While ONC doesn’t have the ultimate decision on incentive criteria, it can create enablers for robust incentive criteria that would inform and allow robust incentive rules requiring health exchange
  - Meaningful use criteria (objectives and measures) that require standards-based exchange
  - Definition of core requirements for exchange to meet recommended meaningful use criteria
  - Certification of interoperability components that adhere to such requirements
### Meaningful Use and Its Impact on HIE

#### Strength of Health Exchange Objectives in Current Version Of MU Rises Substantially by 2013

**Meaningful Use Objectives Requiring Health Exchange**

<table>
<thead>
<tr>
<th>Year</th>
<th>Objectives</th>
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| 2011 | - Lab results delivery  
       - Prescribing  
       - Claims and eligibility checking  
       - Quality and immunization reporting, if available |
| 2013 | - Registry reporting and reporting to public health  
       - Electronic ordering  
       - Health summaries for continuity of care  
       - Receive public health alerts  
       - Home monitoring  
       - Populate PHRs |
| 2015 | - Access comprehensive data from all available sources  
       - Experience of care reporting  
       - Medical device interoperability |

- Increases volume of transactions that are most commonly happening today
  - Lab to provider
  - Provider to pharmacy

- Substantially steps up exchange
  - Provider to lab
  - Pharmacy to provider
  - Office to hospital and vice versa
  - Office to office
  - Hospital/office to public health and vice versa
  - Hospital to patient
  - Office to patient and vice versa
  - Hospital/office to reporting entities

- Starts to envision routine availability of relatively rich exchange transactions
  - “Anyone to anyone”
  - Patient to reporting entities
How Much Intervention Should be Applied to Facilitate Achievement of These MU Objectives?

SPECTRUM OF GOVERNMENT INTERVENTION

- Require specific transactions
  - What to exchange, from whom, to whom

- Also require specific functions and standards
  - For each transaction, standards for communication, content, privacy, security

- Also require specific technologies, architectures, and organization forms (or organizations)
  - For each transaction, legal, business, and governance requirements

Want to strike a balance?
- Too little structure would do nothing to resolve some of the significant barriers that exist today
- Too much structure would stifle innovation by locking in what exists today and artificially channeling product development toward specific technologies or architectures
### HIT Policy Committee HIE Recommendations

<table>
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<th>HIE Recommendations</th>
<th>Details</th>
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<tr>
<td>Information exchange requirements</td>
<td>There should be core information exchange requirements that are technology- and architecture-neutral and would apply to all participants seeking to demonstrate meaningful use to CMS</td>
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<tr>
<td>Core Requirements</td>
<td>Consistent with the recommendations of the Certification Workgroup, these core requirements should be focused on the capability to achieve meaningful use and include interoperability, privacy, and security</td>
</tr>
<tr>
<td>Certification of interoperability components</td>
<td>Federal government should certify EHR and health information exchange components on these core requirements to ease burden on eligible professionals and hospitals for meeting and demonstrating adherence with meaningful use requirements</td>
</tr>
<tr>
<td>Aligning federal and state efforts and bringing existing efforts into alignment</td>
<td>Federal and state-government approaches should be complementary, and grants to states should require alignment with federal meaningful use objectives and measures</td>
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</table>
Additional Points

• Setting criteria that all systems and components must meet allows eligible professionals and hospitals to have a choice among models of exchange while still qualifying for meaningful use incentives (for example, direct or through vendor-specific or transaction-specific hubs, or through national or sub-national networks (HIOs)). For example:
  – Certified EHRs with robust interoperability standards
  – Certified components that have to meet same interoperability standards in order to allow space for market innovation and address transition from non-certified legacy systems

• Systems not seeking or required to be certified would have market incentives to adopt in order to be able to exchange data with certified systems or through certified components

• Consistent with Certification Workgroup recommendations, should be tied to capability to exchange to meet meaningful use criteria in 2011, with a clear pathway to more robust exchange in 2013 and 2015
Additional Points

• Core requirements should be focused on exchange required to meet meaningful use and should include interoperability, privacy, and security

• (1) Interoperability — a basic level of the transport/communication, package and content standards that are necessary to ensure exchange can occur
  – Top priority: transport/communication standards plus container/envelope standards for key clinical payloads so all can at least send and receive human readable data
  – Top priority: measure definitions and semantic standards for clinical data required for 2011 CMS and public health reporting

• (2) Privacy and (3) Security
  – Meet requirements of current law and those enacted in ARRA that will need to be implemented over the next 1 – 3 years

• Policy Committee has a role to play in shaping these requirements and should provide clear guidance to the Standards Committee
Additional Points — Federal/State Interplay

• States may impose state-level requirements on information exchange to satisfy state-level meaningful use definitions. Such requirements should be complementary to federal efforts.

• To qualify for meaningful use, information exchange in a state must meet federal requirements to qualify for Medicare meaningful use payments, and may also be required by a state to meet state-level requirements for receipt of Medicaid meaningful use payments.

• The federal definitions and requirements of meaningful use should be a “floor” for state-level Medicaid meaningful use requirements.
ARRA/HITECH Summary Recommendations for Hospitals and Participating Providers

• Educate Your Leadership
• Check to see if your EHR Vendor Product Release is Certified
• Follow Meaningful Use Regulations Closely—Final Regs December 2009
• Immediately start to review and address where the organization or office is ready to meet the ARRA Meaningful Use Criteria by:
  – Assign a lead and/or workgroup to review existing HIT standards (CCHIT, HL7, CCD, etc.) for all HIT products and applications
  – Conduct a readiness assessment
  – Define current state
  – Develop a future state vision and perform a gap analysis
  – Develop a transition plan to close the gaps
  – Design future requirements for system optimization or selection
  – Develop plan and process for attestation
  – Deploy plan and processes
  – Monitor outcome and revise as necessary

• Prepare for HIE
• Update Security Policies
• Retain Your People!!!!!
• For EHRs to have the comprehensive capabilities required for quality reporting and measurement, the following needs to occur:
  – Development of one standardized national set of quality measures and method for reporting that includes the IT community
  – Development of additional standards for quality measures are needed for data (especially exclusions), reporting formats and mechanisms
    • Coordination should occur by NQF in collaboration with IT standards groups such as HL7/CCD and AHIC
  – Assurance that IT Certification Initiatives have the necessary functionality to support “out of the box” quality reporting activities that do not require extensive local build and customization
    • To lead this effort, we recommend that The Agency for Healthcare Quality (AHRQ) is designated as the Lead Federal Agency in partnership with ONC for this effort
  – Seek assistance from IT experts in the area of quality surveillance and reporting to execute an interim solution supporting activities while the vendors work towards meeting EHR-based quality reporting
Recommendations (cont’d)

• Hospitals should offer technical assistance to physician practices for quality data and measurement activities

• Hospital should extend current case or care manager role to collect data upon admission/discharge and provide it to the physician practice or ambulatory setting to help with data collection

• Seek assistance from IT experts in the area of quality surveillance and reporting to execute an interim solution supporting activities while the vendors work towards meeting EHR-based quality reporting requirements

• Hospitals should reach out to physicians to coordinate collection of future quality measures within the new episode of care model being rolled out by CMS
Questions or Comments?

Thank you!