“Meaningful Use”
(Including HIPAA/HITECH)
Margret Amatayakul
September 16, 2010

Speaker
Margret Amatayakul
RHIA, CHPS, CPHIT, CPEHR, FHIMSS
President, Margret A Consulting, LLC
Co-founder, Health IT Certification, LLC
Independent information management and systems consultant, with a focus on achieving value from electronic health records, HIPAA, and health information exchange

Orientation to the
American Recovery and Reinvestment Act (ARRA) of 2009

Division A: Appropriations Provisions
Title VII: Dept. Labor, HHS, & Education (appropriations)
Title XIII: Health Information Technology for Economic and Clinical Health (HITECH) Act
A: Promotion of HIT (ONC)
B: Testing of HIT
C: Grants and Loans Funding
D: Privacy

To track events:
http://healthit.hhs.gov/

Division B: Tax, Unemployment, Health, State Fiscal Relief, and Other Provisions
Title IV: Medicare and Medicaid HIT (incentives)

Funding from ARRA/HITECH (under ONC) for HIT Infrastructure

• HIT architecture that supports nationwide electronic exchange and use of health information in a secure, private, and accurate manner
• Development and adoption of certified EHRs for providers not eligible for other support
• Training on and dissemination of best practices to integrate HIT, including EHR, into a provider’s delivery of care
• Infrastructure and tools for telemedicine
• Promotion of interoperability of clinical data repositories or registries
• Promotion of technologies that enhance protection of health information
• Improvement and expansion of uses of HIT by public health departments

“Meaningful Use” of EHR Technology

ARRA “Meaningful Use” Incentives

• Meaningful use of EHR: eligible professionals and hospitals demonstrate use of certified EHR technology:
  – In a meaningful manner, which includes use of e-prescribing as determined to be appropriate by the Secretary
  – EHR technology provides exchange of information to improve quality of health care, such as promoting care coordination
  – Reporting of clinical quality measures and other measures selected by Secretary. Measures may become more stringent; however, HHS may not require electronic reporting unless there is the capacity to accept data, which may be on a pilot basis
ARRA Definitions: Certified EHR Technology

(1) A Complete EHR that meets the requirements included in the definition of a Qualified EHR and has been tested and certified in accordance with certification program established by the National Coordinator as meeting all applicable certification criteria adopted by the Secretary; or

(2) A combination of EHR Modules in which each constituent EHR Module of the combination has been tested and certified in accordance with certification program established by the National Coordinator as meeting all applicable certification criteria adopted by the Secretary, and the resultant combination also meets the requirements included in the definition of a Qualified EHR.

ARRA Definitions: Qualified EHR

"...The term ‘qualified electronic health record’ means an electronic record of health-related information on an individual that—

(A) includes patient demographic and clinical health information, such as medical history and problem lists; and

(B) has the capacity—

(i) to provide clinical decision support;

(ii) to support physician order entry;

(iii) to capture and query information relevant to health care quality; and

(iv) to exchange electronic health information with, and integrate such information from other sources.

Three Regulations from ARRA

- **Temporary Certification Program for Health Information Technology**
  - Final Rule, June 24, 2010
  - Process for organizations to test and certify HIT until permanent program is established

- **Health Information Technology: Initial Set of Standards, Implementation Specifications, and Certification Criteria for Electronic Health Record Technology**
  - Final Rule, July 28, 2010
  - Standards, implementation specifications, and criteria for certification of EHR technology

- **Standards for Electronic Health Record Technology Incentive Program (“M.U.”)**
  - Final Rule, July 28, 2010
  - Incentive payments for eligible professionals (EPs), eligible hospitals, and critical access hospitals (CAHs) participating in Medicare and Medicaid programs

EHR Certification Timetable

<table>
<thead>
<tr>
<th>Date</th>
<th>Event Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>July 1, 2010</td>
<td>Applications submitted to ONC</td>
</tr>
<tr>
<td>July/Aug 2010</td>
<td>Applications reviewed; list of accepted “Authorized Testing and Certification Bodies” (ATCBs) issued</td>
</tr>
<tr>
<td>Aug/Sept 2010</td>
<td>ATCBs authorized to test and certify EHR technology</td>
</tr>
<tr>
<td>Fall 2010</td>
<td>Certified products anticipated to be available</td>
</tr>
<tr>
<td>Dec 31, 2011</td>
<td>Temporary certification program eliminated, with potential extension as necessary</td>
</tr>
</tbody>
</table>

ONC-ATCBs

- Certification Commission for Health Information Technology was the only government recognized certification body for EHRs between 2006 and 2009. On August 30, 2010, CCHIT was approved by HHS as an ONC-ATCB. It will offer certification for:
  - Complete EHR products that meet all of the certification criteria for M.U. incentives
  - Modifiable EHR products that meet one or more - but not all - of the M.U. criteria
  - Customized ONC certification program for hospitals that already have their own EHRs based on self-developed products or “off-the-shelf” products that have been customized
  - CCHIT currently offers two complementary, but completely separate certification programs:
    - It adds to HITL certification, CCHIT will continue to offer for ONC-Certified program for Ambulatory and can be EHR products that exceed the HITL/CDC criteria and are designated for use in the ambulatory setting.

Drummond Group, Inc. (DGI) is an interoperability test lab offering global testing services through the product life cycle. Auditing, QA, conformance testing, custom software test lab services, software certification, system services testing, and consulting are offered in addition to interoperability testing. Founded in 1999, DGI has tested over a thousand international software products used in vertical industries such as automotive, consumer product goods, healthcare, energy, financial services, government, petroleum, pharmaceutical and retail. It will offer certification for:

- Complete EHR products that meet all of the certification criteria for M.U. incentives
- Modifiable EHR products that meet one or more - but not all - of the M.U. criteria

- Tailored ONC certification program for hospitals that already have their own EHRs based on self-developed products or “off-the-shelf” products that have been customized

- Modifiable ONC certification program for hospitals that already have their own EHRs based on self-developed products or “off-the-shelf” products that have been customized...
Certification of Minimum Capabilities

- Certification criteria represent the minimum capabilities EHR technology needs to include and have properly implemented in order to achieve certification
  - Other capabilities important to a practice or hospital may not be addressed, such as practice management system (practice), electronic medication administration record (hospital)
- Certification criteria do not preclude Complete EHR developers from including additional capabilities that are not required for purposes of certification
  - Yet these capabilities may still not address usability, workflow, process redesign, or specialty functions

Health Information Technology: Initial Set of Standards, Implementation Specifications, and Certification Criteria for Electronic Health Record Technology

Initial Standards and Criteria

- Standards are protocols that enable meaningful and secure exchange of information
- Implementation specifications describe how standards are used
- Certification criteria refer to the properties EHR technology must possess to be certified

Content Exchange Standards

- Patient Summary Record
  - HL7 Continuity of Care Document (CCD), or
  - ASTM Continuity of Care Record (CCR)
- E-Prescribing
  - NCPDP SCRIPT
- Submission of Lab Results
  - HL7 2.5.1
- Submission for Surveillance and to Immunization Registries
  - HL7 2.3.1, or
  - HL7 2.5.1
- Quality reporting
  - CMS Physician Quality Reporting Initiative (PQRI) 2009 Registry XML Specification

- Health Level Seven HL7 is the predominant organization that establishes standards for protocols used to exchange data among disparate health information systems (e.g., EHR and Laboratory Information System)
- National Council for Prescription Drug Programs (NCPDP) is the predominant organization that establishes standards for protocols used to exchange retail pharmacy eligibility and claims data as well as prescription data

Patient Summary Record Standards

- ASTM CCR is a core data set that supports referrals, transfers, and other uses by different providers
- HL7 CDA is a document markup specification providing a multi-level architecture accommodating varying degrees of markup granularity
- CCR + CDA = CCD may be incorporated into a data exchange by reference to a PDF (in HL7 V2.x) or embedded as an XML format (in HL7 V3)

Vocabulary Standards

- Problems
  - ICD, or
  - SNOMED
- Procedures
  - PCS/CPT as applicable
- Lab results within electronic transaction from a lab
  - LOINC
- Medications
  - Any source vocabulary that is included in RxNorm:
    - First Databank
    - Micromedex
    - MediSpan
    - Gold Standard Alchemy
    - Multum
- Immunizations
  - HL7 Standard Code Set CVX – Vaccines Administered
- Race and Ethnicity

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### ICD/PCS and CPT
- International Classification of Diseases (ICD) is a standard international clinical classification of diseases and health problems recorded on death certificates as the basis for national mortality and morbidity statistics by the WHO Member States.
- Across the world, ICD is used to classify diseases and other health problems. In the U.S., ICD-9-CM, the ninth edition of a clinical modification (CM) created by the U.S. is also used in reimbursement functions.
- The U.S. will adopt ICD-10-CM in October 2013.
- Because the international version of ICD does not include a Procedure Classification System (PCS), this has been developed by the U.S.

### SNOMED-CT
- SNOMED CT (formerly Systematized Nomenclature of Medicine—Clinical Terms) is considered to be the most comprehensive, multilingual clinical health care terminology in the world. RxNorm is a vocabulary that always reflects the language of the provider or patient. Because the SNOMED is also used in reimbursement functions, SNOMED is a vocabulary that always reflects the language of the provider or patient.
- By providing links between these vocabularies, RxNorm can mediate messages between systems not using the same software and vocabulary.

### Other Vocabularies
- Logical Observation Identifiers Names and Codes (LOINC) was developed by the Regenstrief Institute, initially for the purpose of encoding laboratory data, and subsequently other types of observational data, including vital signs, history and physical exam information, etc.
- RxNorm is a standardized nomenclature for clinical drugs produced by the National Library of Medicine. It provides normalized names for clinical drugs and links its names to many of the drug vocabularies commonly used in pharmacy management and drug interaction software. By providing links between these vocabularies, RxNorm can mediate messages between systems not using the same software and vocabulary.

### Data Protection Standards
- **Protection of Electronic Health Information Created, Maintained, and Exchanged**
  - Encryption and decryption
  - Any encryption algorithm identified by NIST as approved in FIPS PUB 140-2
  - Record actions
    - Date, time, patient identification, and user identification must be recorded when electronic health information is created, modified, accessed, or deleted; an indication of which action(s) occurred and by whom must also be recorded.

  - Verification that electronic health information has not been altered in transit
    - Hashing algorithm equal to or greater than SHA-1 identified by NIST in FIPS PUB 198-3
    - Record treatment, payment, and health care operations disclosures
      - Date, time, patient identification, user identification, and a description of the disclosure must be recorded for disclosures for treatment, payment, and health care operations as defined at 45 CFR 164.501 (HIPAA).

### Vocabulary Mapping
- The ultimate goal of an EHR with respect to data is C.O.D.E.:
  - Capture clinically specific data
  - Once at the point of care
  - Derive information there from
  - Every other purpose.
- As standards are being adopted for EHRs, ICD or SNOMED are included as a means to standardize data for many purposes for which data are used in healthcare. However, neither ICD nor SNOMED are vocabularies that always reflect the language of the provider or patient. Both, a combination of lay terms and general clinical terms may be used instead.
- The National Library of Medicine (NLM) has done extensive work on mapping a variety of health care vocabularies to SNOMED and among some other vocabularies, including some proprietary terminologies which may be more "user friendly," such as MEDCIN. So an important consideration in selecting an EHR may be to evaluate not only if the problem list is recorded in ICD or SNOMED, as required by the certification criteria, but whether mapping is available and desirable.

### “Privacy” in ARRA/HITECH
- Modifications to the HIPAA Privacy, Security, and Enforcement Rules under HIPAA (Proposed Rule, July 14, 2010)
  - Business associate requirements to comply with provisions of Privacy & Security Rules
  - Strengthening of patient rights to access, minimum necessary, accounting for disclosures through EHRs, and restrictions in uses and disclosures of protected health information (PHI)
  - Tightening of controls on selling PHI, use of PHI for marketing and fund raising, and potentially unauthorized uses and disclosures
  - Amendment of penalties
    - Increased civil monetary penalties
    - Strengthening of patient rights to access, minimum necessary, accounting for disclosures through EHRs, and restrictions in uses and disclosures of protected health information (PHI)
    - Business associate requirement to comply with provisions of Privacy & Security Rules

- HHS Regional Office Privacy Advisors and Education on Health Information Privacy
- Delegation of Authority for Security Rule Enforcement from CMS to Office for Civil Rights (OCR) (August 4, 2009)
- Breach Notification
  - HHS Breach Notification for Unsecured PHI (FPR, August 24, 2009)
  - Guidance Specifying the Technologies and Methodologies That Render PHI Indecipherable to Unauthorized Individuals for Purposes of the Breach Notification Requirements of ARRA/HITECH (FPR, April 27, 2009)
Medicare and Medicaid Incentive Program
Standards for Electronic Health Record Technology Incentive Program

Meaningful Use Criteria
HIT Policy Committee in original proposal for meaningful use criteria urged CMS to follow National Quality Forum (NQF) Health Outcomes Priority: • Improve quality, safety, efficiency, and reduce health disparities – Provide access to comprehensive patient health data for patient’s health care team – Use evidence-based order sets and CPOE – Apply clinical decision support at the point of care – Generate lists of patients who need care and use them to reach out to patients – Report information for quality improvement and public reporting • Engage patients and their families in their health care – Provide patients and families with timely access to data, knowledge, and tools to make informed decisions and to manage their health • Improve care coordination – Exchange meaningful clinical information among professional health care team • Improve population and public health health – Communicate with public health agencies • Ensure adequate privacy and security protections for personal health information – Ensure privacy and security protection for confidential information through operating policies and procedures, and technologies and compliance with applicable law – Provide transparency of data sharing to patient

Key Definitions
• Reporting period for Eligible Professional (EP): – For first payment year, any continuous 90-day period within calendar year (Cy); – except for Medicaid providers who first demonstrate M.U. in their second payment year; – thereafter calendar year • Reporting period for Eligible Hospital (EH) or Critical Access Hospital (CAH): – For first payment year, any continuous 90-day period within a Federal fiscal year (FY); – thereafter, Federal fiscal year • Eligible professional for Medicare Incentives: MD or DO, DDS, DP, OD, DC – Hospital-based EP furnishes 90% or more of services in the year preceding the payment year in an inpatient hospital (Place of Service [POS] code 21) or emergency room (POS code 22) setting • Continuing Extension Act of 2010, April 15, 2010 excluded POS code 22 (outpatient setting) • Eligible hospital is an “acute care hospital” or “children’s hospital.” For purposes of the Medicare incentives, this includes any hospital system with multiple facilities that has sought one CMS Certification Number (CCN) as one EH for purposes of the incentive. Critical access hospitals are also eligible for Medicare incentives (although with a different incentive structure)

M.U. Objectives and Measures: Stage 1 Criteria
• Core Set – All 15 (for EPs)/14 (for Hs) objectives and associated measures of the Core Set must be met, except where there are explicit exclusions for non-applicable objectives • Menu Set – Five of 10 objectives of the participant’s choice from the Menu Set must be met, except where there are explicit exclusions for non-applicable objectives • Measures: – Yes/No (Y/N) – % (Numerator/Denominator) • Measures with a denominator of all unique patients (all pts) regardless of whether the patient’s records are maintained using certified EHR technology • Measures with a denominator based on counting actions for patients whose records are maintained using certified EHR technology

CORE SET Stage 1
Objectives (Standards)
1. Use CPOE for medication orders directly entered by any licensed health care professional
2. Implement drug-drug and drug-derivative interaction checks
3. Generate and transmit permissible prescription electronically (eRx)
4. Record demographics:
   • Date of birth
   • Height, weight, blood pressure
   • Race
   • Ethnicity
   • Date of birth
   • Date/preliminary cause of death
5. Maintain up-to-date problem list of current and active diagnoses (ICD-9-CM or SNOMED-CT)
6. Maintain active medication list (RxNorm)

EPH Measures Application
1. Use CPOE for medication orders directly entered by any licensed health care professional Both ≥85% of all pt’s write medication on EHR med list have ≥1 order entered via CPOE
2. Implement drug-drug and drug-derivative interaction checks Both ≥80% of all medications on EHR med list have ≥1 interaction entered via CPOE
3. Generate and transmit permissible prescription electronically (eRx) (RxNorm) Both ≥40% transmitted via EHR
4. Record demographics:
   • Date of birth (≥50% recorded as structured data for all pts)
   • Height, weight, blood pressure (≥50% recorded as structured data for all pts)
   • Race (≥50% recorded as structured data for all pts)
   • Ethnicity (≥50% recorded as structured data for all pts)
   • Date of birth (≥50% recorded as structured data for all pts)
   • Date/preliminary cause of death (≥50% recorded as structured data for all pts)
5. Maintain up-to-date problem list of current and active diagnoses (ICD-9-CM or SNOMED-CT) Both ≥85% of all pts have one entry or indication of no problem recorded as structured data
6. Maintain active medication list (RxNorm) Both ≥80% of all pts have at least one entry recorded as structured data

CORE SET Stage 1, Continued
Objectives (Standards)
7. Maintain active medication allergy list Both ≥85% of all pts have at least one entry recorded as structured data
8. Record/patient changes in V/S:
   • Height, weight, blood pressure
   • Calculate and display BMI
   • Plot and display growth charts (for 2-20 yrs, including BMI)
9. Record smoking status ≥13 yr Both ≥85% unique pts ≥13 y/o recorded as structured data in EHR
10. Implement one CDS rule relevant to specialty or high clinical priority, timeliness to track compliance with
    exclusion if no pts height, weight, BMI recorded as structured data in EHR
11. Provide pts on request electronic copy (ICD-9-CM or SNOMED-CT) of:
    • Diagnostic test results
    • Problem list
    • Medication list
    • Allergies list
    • Discharge summary
    • Procedures
    • Problem list
    • Procedures
    • Vital signs
    • Vital signs

EPH Measures Application
7. Maintain active medication allergy list
   Both ≥85% of all pts have at least one entry recorded as structured data
   • Problem List
   • Mapping logicalhl
8. Record/patient changes in V/S:
   • Height, weight, blood pressure (≥85% recorded as structured data for all pts)
   • Calculate and display BMI (≥85% recorded as structured data for all pts)
   • Plot and display growth charts (for 2-20 yrs, including BMI) (≥85% recorded as structured data for all pts)
   • Vital signs
   • Vital signs
9. Record smoking status ≥13 yr (≥85% unique pts ≥13 y/o recorded as structured data in EHR)
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    • Logicall
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    • Problem list
    • Medication list
    • Allergies list
    • Discharge summary
    • Procedures

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**Clinical Quality Measures (CQMs)**

- National Quality Forum (NQF) endorsed measures are given preference.
- CMS sought to avoid duplicative and redundant reporting, specifically between:
  - Physician Quality Reporting Initiative (PQRI) for EPs
  - Reporting Hospital Quality Data for Annual Payment Update (RHQDA) for EHs and CAHs (aka, “Core Measures”)
- Detailed electronic specifications of CQMs are displayed at:

**Core CQMs for All EPs**

- **Core Measures**
  - Hypertension: Blood pressure management
  - Preventive care and screening: Tobacco use assessment and cessation intervention
  - Adult weight screening and follow up
- **Alternate Core Measures**
  - Weight assessment and counseling for children and adolescents
  - Preventive care and screening: influenza immunizations for ≥50 y/o
  - Childhood immunization status
- **An EP will not be excluded from reporting any core or alternate CQM because the measure does not apply to the EP’s scope of practice or patient population.**
- The expectation is that the EHR will automatically report on each core CQM, and when one or more of the core measures has a denominator of zero then the alternate core measure(s) will be reported.
- If all six CQMs have zeros for denominators, then the EP is still required to report on three additional CQMs of their choosing from the 44 measures in Table 6.

**TABLE 6 - Clinical Quality Measures for Submission by EHs or EHs and CAHs for the 2011 and 2012 Payment Year**

**CQM Topics for EPs**

- Diabetes
- Heart Failure
- Coronary Artery Disease
- Influenza vaccination
- Pneumovax
- Childhood immunizations
  - Breast
  - Cervical
- Venous Thromboembolism (VTE)
- Smoking cessation

**CQMs for Submission by EHs and CAHs for Payment Year 2011-2012**

- Fifteen measures address:
  - Emergency Department Throughput
  - Stroke
  - Venous Thromboembolism (VTE)
Participation Requirements

- In first payment year, EP, EH, or CAH must submit in manner specified by CMS the following information:
  - Name
  - NPI
  - Business address and phone number
  - Such other information as specified
  - EP submit Taxpayer Identification Number (TIN), which may be EP’s Social Security Number (SSN)
  - EH or CAH must submit CMS Certification Number (CCN) or Taxpayer Identification Number (TIN)
- EP must elect to participate in Medicare or Medicaid (in only one state), although may switch once for a payment year before 2015
- EPs are permitted to realign their (entire) incentive payments to (only one of) their employer or entity with which they have contractual arrangement allowing employer or entity to bill and receive payment for EP’s covered professional services

Demonstration of M.U. Criteria

- For CY or FY 2011: Attest, through a secure mechanism, in a manner specified by CMS (or for a Medicaid participant, by the State) that during the reporting period:
  - Used certified EHR technology, and specify technology used
  - Satisfied required objectives and associated measures
  - Specify EHR reporting period and provide result of each applicable measure for all patients seen (or admitted to inpatient or emergency department) during EHR reporting period for which selected measure is applicable
  - Exceptions for Medicaid, where EHR has been adopted, implemented, or upgraded in first payment year, need not demonstrate meaningful use until second payment year
- Keep documentation supporting demonstration for 6 years
- For CY or FY 2012 and subsequent years: Attest as above, except must report clinical quality information in manner specified by CMS or the State

M.U. Medicare Payments for EPs

<table>
<thead>
<tr>
<th>Payment Year</th>
<th>Incentive subject to per EP cap of 75% of Medicare allowed charges in year</th>
</tr>
</thead>
<tbody>
<tr>
<td>First year if 2011 or 2012</td>
<td>$18,000</td>
</tr>
<tr>
<td>First year if before 2012</td>
<td>$10,000</td>
</tr>
<tr>
<td>Second year</td>
<td>$12,000</td>
</tr>
<tr>
<td>Third year</td>
<td>$8,000</td>
</tr>
<tr>
<td>Fourth year</td>
<td>$4,000</td>
</tr>
<tr>
<td>Fifth year</td>
<td>$2,000</td>
</tr>
<tr>
<td>Second year if health professional shortage area</td>
<td>$0</td>
</tr>
<tr>
<td>If EHR is adopted after 2014</td>
<td>$0</td>
</tr>
<tr>
<td>If EP not EHR user by 2015</td>
<td>99% of reimbursement</td>
</tr>
<tr>
<td>If EP not EHR user by 2016</td>
<td>98% of reimbursement</td>
</tr>
<tr>
<td>If EP not EHR user by 2017</td>
<td>97% of reimbursement</td>
</tr>
<tr>
<td>Succeeding payment years</td>
<td>97% of reimbursement</td>
</tr>
</tbody>
</table>

M.U. Medicaid Payments for Subsection D (PPS) Hospitals

- For a hospital with more than 23,000 acute care inpatient discharges, initial amount is capped at $6,370,200. Hospitals may also earn Medicaid incentives, which carry a similar payment structure

M.U. Medicaid Incentives

- States, at their option and with Federal financial participation (FFP), may provide incentive payments to Medicaid providers for adopting, implementing, or upgrading certified EHR technology or for meaningful use of such technology
- Definition of EPs is expanded
- To qualify, Medicaid patient volume threshold must be:

<table>
<thead>
<tr>
<th>Entity</th>
<th>Minimum 90-day Medicaid Patient Volume Threshold</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physicians</td>
<td>30%</td>
</tr>
<tr>
<td>Pediatricians</td>
<td>20%</td>
</tr>
<tr>
<td>Dentists</td>
<td>30%</td>
</tr>
<tr>
<td>Certified nurse midwives</td>
<td>30%</td>
</tr>
<tr>
<td>Physician Assistants when practicing at an FQHC or RHC led by a physician assistant</td>
<td>30%</td>
</tr>
<tr>
<td>Nurse Practitioners</td>
<td>30%</td>
</tr>
<tr>
<td>Acute care hospital</td>
<td>10%</td>
</tr>
<tr>
<td>Children's hospital</td>
<td>N/A</td>
</tr>
</tbody>
</table>

- Payment may not exceed 85% of maximum threshold of $25,000, which equals $21,250.
- Medicaid EPs are responsible for remaining 15% of net average allowable cost of certified EHR technology, or $3,750 for first payment year.
- For a provider who does not meet the 30% Medicaid patient volume, but meets 20%, the maximum payment in Year 1 is $14,167, and subsequent years $5,667; for a maximum of $42,500.
- EP may not earn both Medicare and Medicaid incentives in one year, but may switch once

M.U. Medicare Payments for EPs

- Payment may not exceed 85% of maximum threshold of $25,000, which equals $21,250.
- Medicaid EPs are responsible for remaining 15% of net average allowable cost of certified EHR technology, or $3,750 for first payment year.
- For a provider who does not meet the 30% Medicaid patient volume, but meets 20%, the maximum payment in Year 1 is $14,167, and subsequent years $5,667; for a maximum of $42,500.
- EP may not earn both Medicare and Medicaid incentives in one year, but may switch once
Preparing for M.U.

M.U. Assessment

- Convene a multi-stakeholder steering committee; establish goals for M.U.
- Use M.U. checklist to determine what your current IT can and cannot do; how well users are actually using EHR technology:
  - Functionality
  - Utilization: compliance with functionality/workflow and process workarounds, skills, infrastructure needs, outcomes
  - Standards compliance
  - Reporting capability
- Critically evaluate ability to address gaps within timeframe of incentives
  - Plot a migration path to address gaps
  - Identify timeframe in which you realistically can earn incentives
- Contact your vendor to:
  - Determine what upgrades/additional modules are available to fill gaps
  - Learn of plans for addressing product gaps and seeking certification
- Where applicable, seek assurances that certification criteria will be met within agreed upon timeframe
- Prepare your organization to adopt the technology in a manner that enables meaningful use:
  - Review and approve clinical quality measures for adoption
  - Redesign workflows and improve processes
  - Retrain, reinforce best practices
  - Institute continuous monitoring and follow up

Questions?
Jerri Hiniker, Program Manager
952-853-8540 or 877-787-2847
jhiniker@stratishealth.org

Creating “Meaningful Users”

- Recognize that implementation is not adoption; and that just “using” an EHR is not necessarily achieving optimal value
  - To produce measures of use through the EHR, it must be adopted by clinicians
  - To get true value from an EHR - all features must be regularly used, including continuous feedback mechanisms
- Engage clinicians early and often (in selection or optimization) in meaningful dialogue
  - Not meetings, but “curbside consultations”
  - Not directives, but collaborative decision-making
- Understand organizational culture and determine best change management strategies
  - Big bang works for some, not others
  - “Show one, do one” works for physicians; not necessarily for nurses
- Follow the 80/20 rule: EHR success is largely dependent on workflow and process, not hardware and software

HIMSS Analytics™ EHR Adoption (N=5235)

<table>
<thead>
<tr>
<th>Stage</th>
<th>HOSPITAL Cumulative Capabilities</th>
<th>2009 Final</th>
</tr>
</thead>
<tbody>
<tr>
<td>7</td>
<td>Complete EMR, CCD, data warehousing; IP, ED, OP data exchange</td>
<td>0.7%</td>
</tr>
<tr>
<td>6</td>
<td>MD templates, full CDS, full R-PACS</td>
<td>1.6%</td>
</tr>
<tr>
<td>5</td>
<td>Closed loop medication administration</td>
<td>3.8%</td>
</tr>
<tr>
<td>4</td>
<td>CPOE, CDS</td>
<td>7.4%</td>
</tr>
<tr>
<td>3</td>
<td>RN documentation, D-D in Pharmacy, PACS</td>
<td>50.9%</td>
</tr>
<tr>
<td>2</td>
<td>Controlled vocabulary, CDR, CDS, may have document imaging, HIE</td>
<td>16.9%</td>
</tr>
<tr>
<td>1</td>
<td>Lab, Radiology, Pharmacy</td>
<td>7.2%</td>
</tr>
<tr>
<td>0</td>
<td>All 3 ancillaries not installed</td>
<td>11.5%</td>
</tr>
</tbody>
</table>

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