



**Beyond Meaningful Use
Health Enterprise Network and Bluegrass HIMSS
January 19, 2010**

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Dedicated to *Hope, Healing* and *Recovery*

Disclaimer

Not speaking on behalf of the Federal Health IT Policy Committee, any of its Workgroups, or the Office of the National Coordinator for Health IT

ARRA/HITECH

Health Information Technology for Economic and Clinical Health

- Goals

- Improved quality at a reduced cost
- For individuals and for the overall population

- Signed February 17, 2009

- Technology is part of achieving overall healthcare reform

- ARRA/HITECH created in law

- The Office of the National Coordinator for Health IT (ONC)
- Two Federal Advisory Committees
 - Health Information Technology Policy Committee
 - Health Information Technology Standards Committee
- Annual Strategic HIT Plan
- Enhanced Privacy and Security (HIPAA Updated)
- Funding for HIT

Federal Advisory Committees

HIT Policy Committee

- Policy framework for the development and adoption of a nationwide health IT infrastructure
- Areas in which standards, implementation specifications, and certification criteria are needed

HIT Standards Committee

- Standards
- Implementation specifications
- Certification criteria

Committee Activities

- Workgroups
- Public Hearings
- *Recommendations* to the National Coordinator

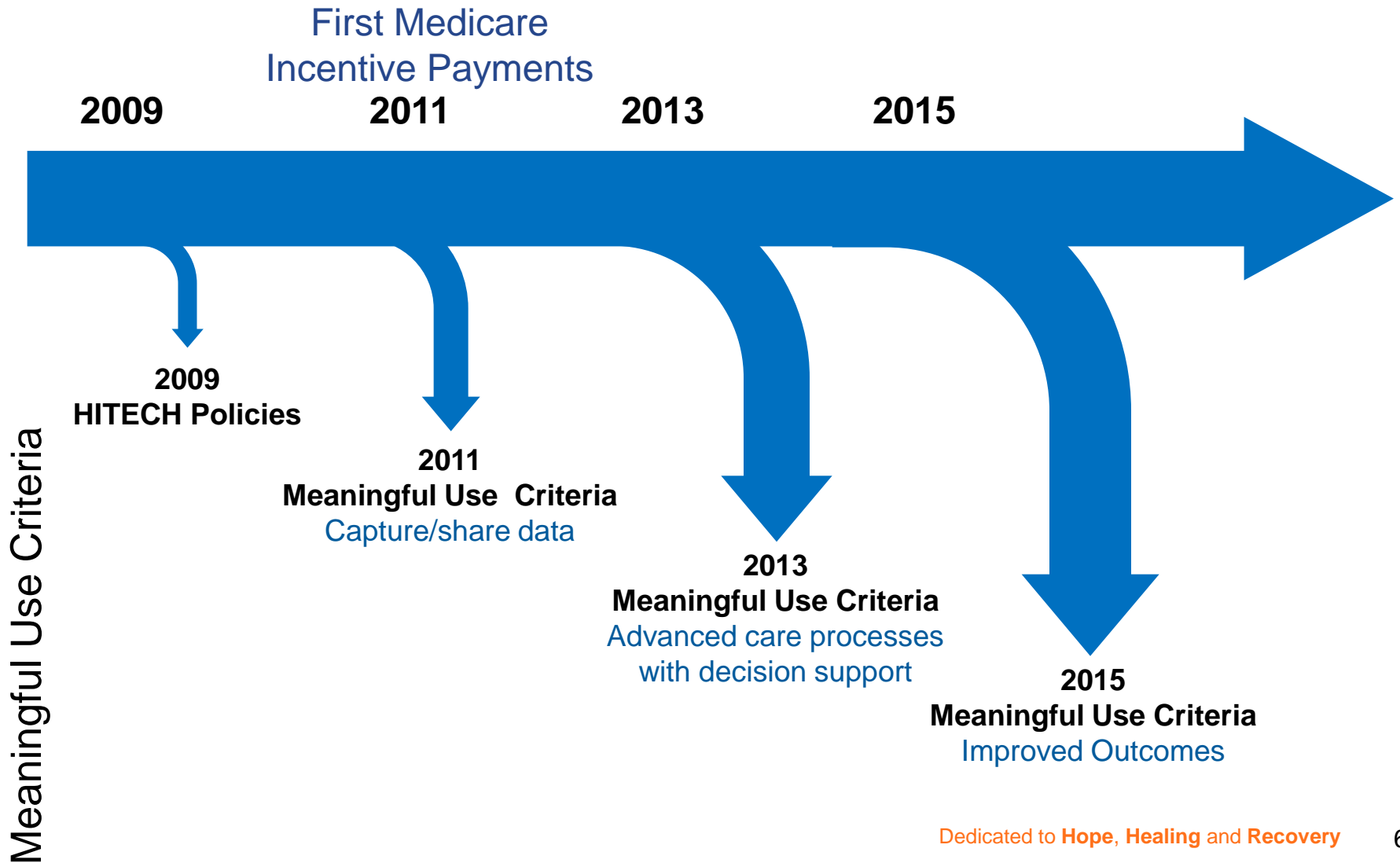
HITECH Established and Funded

- Office of the National Coordinator for Health IT (staff and programs)
- Incentives for Adoption of Health IT
- Regional Extension Centers for training and support
- National Health Information Network (NHIN)
- State Health Information Exchanges
- Strategic Health IT Advanced Research Projects (SHARP)
- Beacon Communities (examples of excellence)
- Workforce development
 - Community college consortia training programs
 - Curriculum development centers
 - University-based training program
 - Competency examination program
- Infrastructure for health IT
- Comparative effectiveness research

Payment for Use

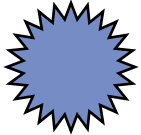
- Medicare and Medicaid Providers
 - Physician Practices (Medicaid eligible providers include physicians, dentists, certified nurse-midwives, nurse practitioners, and physician assistants)
 - Acute Care Hospitals, Critical Access Hospitals, Children's Hospitals
- Payment Criteria
 - Meaningful use of a certified EHR
 - Exchange of health information
 - Data reporting
- June 2010: HHS to address other providers in a Report to Congress (includes Skilled Nursing Facility, Home Health Agency, Inpatient Rehab Facility, Long-Term Acute Care Hospital, and others)

Timeline for Meaningful Use



First Incentive Payments

Pre-Publication of Proposed Rules



December 2009

Public Comment
(60 days starting January 13, 2010)

January 2010

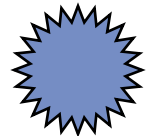
February 2010

Preparation of Final Rules &
OMB Review (60 days)

March 2010

April 2010

Publication of Final Rules



May 2010

Final Rules for Incentive Payments and Associated Standards



Criteria for Meaningful Use

Criteria for Certified Electronic Health Record

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Implementation by Eligible Providers and Acute-Care Hospitals

Meaningful Use of a Certified EHR by Providers



First Incentive Payments

October, 2010 (Hospitals) & January 2011 (Individual Providers)

Preliminary Regulations

Issued December 30, 2009 / Published January 13, 2010

- CMS
 - Meaningful Use Objectives and Measures
 - Quality Measures
 - Incentive Payment Process
- ONC
 - EHR Certification Criteria
 - Interoperability Standards for Message Structure and Content

Expected January 2010

- ONC
 - Process for Certification of EHR's

Incremental Approach

- Stage 1
 - Proposed rules address specific goals for 2011 and 2012
- Stage 2 & Stage 3
 - Future rules will specify the goals for these Stages
- Providers begin at Stage 1 and advance over time
- By 2015 all are at Stage 3

<i>First Payment Year</i>	Payment Year				
	2011	2012	2013	2014	2015
<i>2011</i>	Stage 1	Stage 1	Stage 2	Stage 2	Stage 3
<i>2012</i>		Stage 1	Stage 1	Stage 2	Stage 3
<i>2013</i>			Stage 1	Stage 2	Stage 3
<i>2014</i>				Stage 1	Stage 3
<i>2015</i>					Stage 3

Medicare Incentive Payments and Timelines



	2011	2012	2013	2014	2015	2016
Eligible Professionals / Individual Physicians						
Incentive Payment Window	Starting 1/1/2011					
Maximum Payment (5 years starting 2011)	\$18,000	\$12,000	\$8,000	\$4,000	\$2,000	
Maximum Payment (5 years starting 2012)		\$18,000	\$12,000	\$8,000	\$4,000	\$2,000
Other than Max Payment (starting 2013)			\$15,000	\$12,000	\$8,000	\$4,000
Other than Max Payment (starting 2014)				\$12,000	\$8,000	\$4,000
Medicare fee schedule adjustment for non-use (additional rules for Medicaid providers)					1% reduction	2% reduction
Hospitals						
Incentive Payment Window	Starting 10/1/2010					
Maximum Payment (4 years starting FY 2011)	\$2,000,000 base	\$1,500,000 base	\$1,000,000 base	\$500,000 base		
Maximum Payment (4 years starting FY 2012)		\$2,000,000 base	\$1,500,000 base	\$1,000,000 base	\$500,000 base	
Maximum Payment (4 years starting FY 2013)			\$2,000,000 base	\$1,500,000 base	\$1,000,000 base	\$500,000 base
Other than Max Payment (starting FY 2014)				\$1,500,000 base	\$1,000,000 base	\$500,000 base
Other than Max Payment (starting FY 2015)					\$1,000,000 base	\$500,000 base
Market basket adjustment for non-use (alternative rules for Critical Access Hospitals) (alternative rules for Children's Hospitals) (additional rules for Medicaid providers)					25% reduction	50% reduction
Meaningful Use Criteria						
2011 First Payment Year	Stage 1	Stage 1	Stage 2	Stage 2	Stage 3	...
2012 First Payment Year		Stage 1	Stage 1	Stage 2	Stage 3	...
2013 First Payment Year			Stage 1	Stage 2	Stage 3	...
2014 First Payment Year				Stage 1	Stage 3	...
2015 First Payment Year					Stage 3	...

Payment for hospitals is further adjusted for discharge volume and Medicare % of patient days

Meaningful Use Highlights

- Improving quality, safety, efficiency, and reducing health disparities
 - CPOE (Computerized Provider Order Entry)
 - Drug-drug, drug-allergy, drug-formulary checks
 - Problem list based on ICD-9-CM or SNOMED CT®
 - Electronic Prescribing (eRx) for outpatient meds
 - Active medication list
 - Active medication allergy list
 - Vital signs (height, weight, BP, BMI, growth charts)
 - Clinical lab-test results as structured data
 - Report quality measures to CMS or the States
 - Implement 5 clinical decision support rules
 - Generate patient lists with specific conditions
 - Check insurance eligibility electronically
 - Submit claims electronically

Meaningful Use Highlights (continued)

- Engage patients and families
 - Provide patients with an electronic copy of their health information
 - Provide patients with an electronic copy of their discharge instructions and procedures or visit summary
 - Provide patients with timely electronic access to their health information (including lab results) (outpatient requirement)
- Improve care coordination
 - Capability to exchange clinical information
 - Medication reconciliation
 - Provide summary care record
- Improve population and public health
 - Submit electronic data to immunization registries (as available)
 - Electronic syndromic surveillance data to public health agencies
- Ensure adequate privacy and security
 - Security risk analysis
 - implementation of appropriate technical capabilities

Quality Measures

- Outcomes data as a by-product of care integrated in the EHR
- Measures endorsed by NQF (National Quality Forum) including existing programs:
 - Physician Quality Reporting Initiative (PQRI)
 - Reporting Hospital Quality Data for Annual Payment Update (RHQDAPU)
- Physicians: 90 total, 3 core for all physicians, others by specialty
- Hospitals: 43 measures
- For 2011, submit limited data electronically plus additional summary data manually; attest that the data came from the EHR
- For 2012 and beyond, submit detailed data electronically (contingent on CMS being ready to accept)

Standards for Interoperability

- Vocabulary Standards
- Content Exchange Standards
- Transport Standards
- Privacy and Security Standards

- Standards apply to interchange of data between organizations
- Stage 1 allows for more than one option moving to a single standard in Stage 2 or Stage 3
 - For example, Stage 1 requires EHR's to accept both HL7 CCD and ASTM CDR format clinical summaries but need only produce one of these formats, moving toward a single combined standard for Stage 2
- Vocabularies proposed for broader adoption in Stage 2:
 - SNOMED for problem lists, RxNorm for medications, UNII for medication allergies, UCUM for units of measure, LOINC for labs

Health Information Exchange

ONC Approach to Health Information Exchange

- Build on existing standards
- Require provider systems to be capable of standards-based exchange
- National Health Information Network (NHIN) to provide the backbone services to support information exchange (for example, provider directory services and security protocols)
- Funding for state-level health information exchanges
- Three models for exchange, still under discussion
 - Provider to provider as patient moves from one location to another (providers control)
 - Provider to/from patient's Personal Health Record (patient controls)
 - Provider to/from a health record repository (third-party controls)
- No clear economic model to sustain health information exchange organizations.

EHR Certification Process

Recommendations from the HIT Policy Committee

- Definition of criteria separate from testing
- Accreditation body to certify certification bodies (the testers)
- One or more certification bodies
- Restrict certification criteria to specifically address meaningful use
- Support commercial, open-source and self-developed systems
- Transition from prior certification process (CCHIT) with focused gap analysis

ONC is expected to issue proposed rules in January 2010.

The Challenge

Are the incentives sufficient to overcome the obstacles?

- CPOE with interaction checks, med reconciliation, structured lab results and electronic copies of health information to patients
 - *Rapid change to care processes without compromising outcomes or overwhelming staff*
 - *Process and outcomes data available for submission*
- Systems must be certified
 - *Vendor development timeline*
 - *Certifier must handle volume of testing*
- Systems must be upgraded to certified version
 - *Providers must implement quickly*
- Systems must be capable of exchanging information
 - *Limited experience with plug-and-play clinical standards*
- Actual interchange depends on availability of infrastructure
 - *New technology will need time to mature*
 - *Infrastructure organizations need time to build trust*
- Ability for CMS, Public Health and others to receive data
 - *Government capabilities must mature quickly to accept public health data, EHR usage measures and quality measures*