



HITECH UPDATE – version 4

Doug Ritchie

EFormatix

Central Oregon Electronic Medical Records

UPDATE ON HITECH LEGISLATION

- EHR Certification requirements
- Meaningful use definition and requirements
- Regional Extension Centers
- Ruminations on the challenges to a successful HITECH implementation nationwide

KEY QUESTIONS

- Are your providers ready to save money?
- Are you willing to wait for the government to legislate that you adopt *their* solution?
- Are you preparing to have interconnection with other practices in your community (saving lots of time and money)?
- Do you know how the Stimulus Act may affect you?
- Do you know that acting on EMR without any stimulus money in mind is the wise choice?

STIMULUS BASICS

BASIC REQUIREMENTS

- The basic requirements of future Stimulus funding for providers are:
 - Providers must use a **certified EHR system**
 - Provider must demonstrate “**meaningful use**”
 - The EHR that is used by the provider must be **connected** to other providers in the community and, if available, in the State or region (multi state possibility)
 - Provider uses **e-prescribing** for ~100% of the scripts issued
 - **PQRI (quality data) is reported regularly** to CMS on a limited number of disease conditions

MEDICARE REQUIREMENTS

- Payments to be calculated by the following method:
 - Payments ONLY to physicians, no mid-levels
 - Compute, by provider, **submitted allowable charges** to Medicare for the period (possibly for the year)
 - Multiply the figure by 75%, up to the capped amount for the yr.
 - For 2011, in order to receive \$18,000 under HITECH the submitted allowable charges must be at least \$24,000.
 - For 2011, and other years, a pro rata computation is possible
 - E.g. if provider only submits \$16,000 in allowable charges then he/she would receive a smaller amount ($\$16,000 / \$24,000 = 66\%$) then the payment to the provider under HITECH would be $66\% \times \$18,000 = \$12,000$

MEDICAID REQUIREMENTS

- Payments to be calculated by the following method:
 - Payments CAN go to PA if they are the lead provider in a rural clinic and a physician, NP, and nurse mid-wife get it but do not have to be rural
 - Total amount can go up to \$64,000 including purchase of EMR
 - 30% threshold of pt census, 20% for pediatrics
INDIVIDUALLY computed – not per practice
 - No computation based on fees – flat payment useful to purchase EMR and pay for maintenance and installation
 - No penalties for non compliance –YET!
 - If other Federal subsidies or Stark monies are available this compensation under HITECH will be reduced

INCENTIVE PAYMENTS

- **Single** physician

	2010	2011	2012	2013	2014	2015
eRx	\$3,506	0	0	0	0	0
PQRI	\$3,506	\$3,506	\$3,506	\$3,506	\$3,506	\$3,506
Stimulus	0	\$18,000	\$12,000	\$8,000	\$4,000	\$2,000

Total five year payout = \$68,542 for single physician

INCENTIVE PAYMENTS

- **Five** physician practice

	2010	2011	2012	2013	2014	2015
eRx	\$17,530	0	0	0	0	0
PQRI	\$17,530	\$17,530	\$17,530	\$17,530	\$17,530	\$17,530
Stimulus	0	\$90,000	\$60,000	\$40,000	\$20,000	\$10,000

Total five year payout = \$342,710 total for five physicians

CURRENT STATUS

- The current status is:
 - Certification is moving towards a useful set of definitions
 - Meaningful use now has preliminary definitions that evolve over the next five years
 - Interoperability is *the key requirement* and will be subject to many new requirements on EHR suppliers
 - EMR to EMR
 - EMR to HIS
 - EMR to labs, ancillary service providers
 - E-Prescribing is here now and widely available
 - PQRI reporting is here now and widely available
 - Patients must be able to obtain access to their personal health records

UPDATE ON HITECH LEGISLATION

- **EHR Certification requirements**
- Meaningful use definition and requirements
- Ruminations on the challenges to a successful HITECH implementation nationwide

STATUS: EHR CERTIFICATION

PROPOSED DEFINITION

- HHS EHR Certification proposed definition:
 - *HHS Certification means that a system is able to achieve the minimum government requirements for security, privacy, and interoperability, and that the system is able to produce the “meaningful use” results that the government expects.”*
 - Note: HHS Certification is not intended to be a “seal of approval” or an indication of the benefits of one system over another.

WHAT IS NEW HERE?

- CCHIT is now moving along two pathways instead of one
 - Comprehensive EHR certification system (as before) for ambulatory, inpatient, and emergency department settings
 - Less comprehensive, more limited, modular inspection program for EHR software focusing only on the standards required for “meaningful use”
- National town hall meeting held by CCHIT on 9/3/2009 to educate participants on the two pathways to certification
- NOTE: Federal regulators are still holding back on a decision as to whether CCHIT or other organizations are going to be the “recognized certification authorities”

CLEAR INCONSISTENCY

- In order to be able to prove meaningful use the definition must be finalized
 - But, as is shown later in this presentation, this will not happen until Spring 2010
- This CCHIT certification effort is a jump start towards the goal line without the definition of meaningful use being finalized
 - Risks of being incorrect for the most part on what meaningful use will finally be determined to be are non-zero but small

IMPACT OF NEW RECOMMENDATIONS

- In the past CCHIT has been the only certifying body for EHR systems
 - It is widely felt that CCHIT has an overly detailed certification process that is seen by some as “too aligned with the EHR supplier industry”
 - CCHIT has always been staffed with volunteers
 - No real conflict has been seen by HIMSS but the appearance of a conflict is important to be addressed
- Now other organizations can enter the arena for certifications
- The preliminary HHS certification rules are to be published by October 2009

TRANSITION TO NEW RULES

- CCHIT has been invited to submit a proposal for developing the preliminary certification process
 - Remember that CCHIT is a volunteer based organization
- Gap certification will be granted to suppliers that are 2008 CCHIT certified but it will be required of these suppliers to upgrade to meet the 2011 criteria
- These new rules should allow health care providers to move forward on planning, purchasing, and implementing EMR systems as federal officials continue to finalize the meaningful use criteria.

STATUS: MEANINGFUL USE

MEANINGFUL USE

- Timelines are stretching out for final approval
 - Legislation says”*“Not later than December 31, 2009, the Secretary shall ... adopt an initial set of standards, implementation specifications, and certification criteria...”*
 - However ONC Chairman Dr. David Blumenthal has recently announced that meaningful use definitions will follow the following time table:
 - Initial proposals made: June 16, 2009 (done)
 - Public review of proposals: September 2009
 - Final proposal to HHS: December 31, 2009
 - Published specification: mid to late Spring 2010

MEANINGFUL USE

- What does all of this mean?
 - Defining meaningful use is turning out to be much more difficult than imagined in the initial legislation
 - EHR suppliers are left dangling to some degree without having clear requirements
 - All of the leading EHR suppliers will today *guarantee* that their products will meet meaningful use criteria once finalized. No reason to wait.
 - Clearly we know that the definitions of meaningful use will vary and increase over time ramping to full definition by 2015
 - Meaningful use definitions for primary care and specialists will likely be somewhat different
- Experience has shown that it takes 12-18 months from start of an EHR implementation to reach something like “meaningful use”

MEANINGFUL USE 2011

- Additional evolving requirements - 2011
 - For hospitals $\geq 10\%$ of all orders directly entered by CPOE
 - Physicians must be able to check pt insurance eligibility online
 - Physicians must be able to submit all claims electronically
 - Patients must receive timely electronic access to their personal health information including lab results, medications, problem lists, and allergies
 - Physicians must implement one clinical decision rule relevant to specialty or high clinical priority
 - Physicians must record pt smoking status and advanced directives
 - Physicians must report ambulatory quality measures to CMS
 - Physicians must maintain up-to-date lists of current and active diagnoses based on ICD9 or SNOMED

CONSUMER PREFERENCES

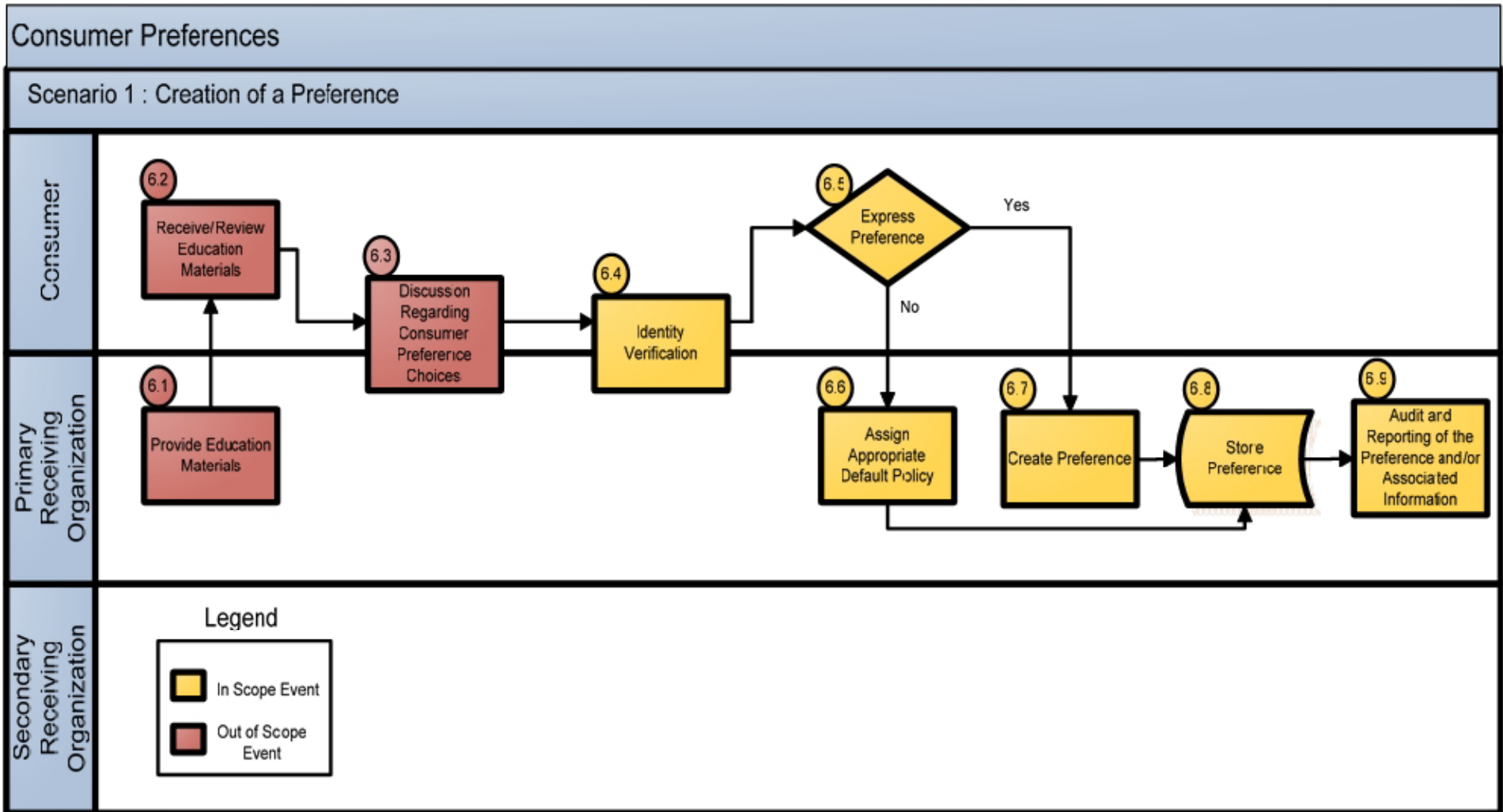
CONSUMER PREFERENCES

- Policy requirements for sensitive and complex topic
 - Protect consumer information in all data exchanges
 - Personal Health Records (PHR)
 - EMR
 - HIE
 - Public health
 - Quality Reporting
 - Research data
 - Draft document now available from HHS/ONC (Office of the National Coordinator of HIT)
 - Available from our website www.coemr.com

CONSUMER PREFERENCES

- Groups involved in setting policy
 - Consumer advocacy groups and policy setting organizations
 - Standards development organizations
 - Providers
 - Consumers and general public
- Basic outcomes expected
 - Definitions of “who can see my information”
 - Consumer preferences on what can and should be shared
 - Ability of consumers to authorize release of info to third parties
- If interested in participating you can send your comments to <http://www.hhs.gov/healthit> and go to Standards and Certification on left panel and Use Cases and Requirements

HITSP PROCESS FOR PROTECTION OF DATA



NEW: REGIONAL EXTENSION CENTERS

REGIONAL EXTENSION CENTERS

- Purpose of these centers
 - Assist providers to select and implement EHR technologies
 - Based on the example of the agricultural extension offices which were established over 100 years ago
 - Provide on-the-ground health IT trainers and implementation experts to facilitate small medical practices' adoption of EHR especially in rural and under-served areas
- Plan is to fund some 70 centers across the US through a grant that totals \$598M

REGIONAL EXTENSION CENTERS

- Fundamental ideas
 - Share the existing knowledge and experience
 - Work with IPA's where possible
 - All REC units are strongly encouraged to network with other REC units for best practices adoption
 - Hopefully adoption of best practices will reduce cost and complexity of EHR adoption for providers nationwide
- In Oregon
 - REC proposal has reached preliminary approval from ONC and now a formal proposal is being developed
 - This formal proposal will work with the IPA's in Oregon

REC - CHALLENGES

- Funding
 - Bulk of money to be spent in first two years
 - Not-for-profit organization lifetimes are unknown
 - Each REC will have to develop a self sustaining business model in order to continue in 3rd year and beyond
 - Each center is assumed to support ~1,000 providers with an emphasis on primary care docs in groups of 10 or fewer
 - Requirement that the REC must provide “generic services” over a wide range of products but they may provide more in-depth support for a narrow list of EMR supplier systems

OVERALL CHALLENGES WE FACE

OVERALL CHALLENGES OF HITECH

- Complexity
 - Seems to be getting more complex, not less complex
- Politics
 - What role(s) will the resolution of the current national debate on health care have in terms of back pressure on HITECH?
- Bureaucracy
 - So many committees, forums, experts, opinions
- Understaffing of key areas
 - Ironical that there is so much money potentially available but seemingly so little of it flowing to those that need to make decisions quickly
 - We could not get “cash for clunker” rebates – what will happen here?
- Industrial inertia and in-fighting amongst EHR supplier base

OVERALL CHALLENGES OF HITECH

- Black clouds
 - Where will Medicare and Medicaid land after the national agony over healthcare changes are “resolved”?
 - What reimbursements will we *really expect to see*?
 - The EMR marketplace will be “crazy” in 2010, 2011
- Our position
 - Investments in HIT for ambulatory practices **must, and will, pay the practice dividends IN SPITE of the current and proposed future legislation**
 - The ROI on these investments is usually 1-2 years at most.

OVERALL CHALLENGES OF HITECH

- Funding to providers is enticing but without clear definition of who can qualify and how to submit your utilization of EHR to a “group of some kind” for approval obstacles remain.
- Difficulties in setting up community data exchanges
 - Finding a funding model that lasts, not via a grant that runs out
 - Irritability between providers and/or practices that now do not wish to share data with one another
 - The recognition that a heterogeneous environment exists in any community with multiple EHR systems today that meet different levels of interoperability
 - Lack of clear standards today on just what interoperability means
 - The *IT technology* of data exchanges is the “easy part”

FIRST REC FUNDING RELEASE PLANS

- Regional Centers to be set up in US
 - Provide outreach, education, technical assistance to providers in a geographical service area to attain or exceed meaningful use criteria.
 - Education
 - Implementation and project management
 - Practice and workflow redesign
 - Functional interoperability and Health Information Exchange (HIE)
 - Privacy and security best practices
 - Progress and training towards meaningful use
 - Local workforce support for training healthcare professionals

MAJOR CHALLENGE!

- If you are thinking of going to EMR and are still waiting then you need to consider what is happening in the marketplace:
 - The marketplace has seen the unintended consequence of “freezing the market” since the Stimulus announcement – but now it has become clear that a “thaw” is beginning across the country
 - As a result of the thawing (or green shoots appearing) it is already a problem for leading EMR suppliers such as eClinicalWorks and Allscripts, both of which are backing up already in terms of implementation schedules
 - A sale today *may get implemented* in January (4 month delay to start) but that date is already in jeopardy at eCW and Allscripts, both of which have leading edge products
 - The forecast is that they will start seeing **6-9 months delay** for implementations by year’s end 2009 signing

CONCLUDING REMARKS

CONCLUDING REMARKS

- Progress is being made on the policies surrounding HITECH
- The definitions are growing more complex with time
- Due to advancing requirements industry consolidation for EHR providers is sure to occur
- Regional consolidation for health exchanges is possible
- The PHR will become important but as an adjunct to the EMR
- “Following the bouncing ball” of this nationwide major change implementation is becoming a small industry in and of itself
- If you are at all thinking of EMR for your clinic – the time is **NOW!**

EMR FOR NON-OWNED PROVIDERS

- Keys to a successful EMR implementation (in order)
 - Governance
 - Cost Modeling
 - Planning for distributed users
 - Management of the implementation project
 - Scaling the infrastructure
 - Creating the model office
 - Funding strategies
 - Implementation order
 - Support

SLIDES ARE AT WWW.COEMR.COM

Link on home page to Stimulus Information

Do you have more questions?

Doug Ritchie – EFormatix

dritchie@eformatix.com

541.585.2588

INCENTIVES – URBAN CLINIC

URBAN CLINIC					
	Adopt	Adopt	Adopt	Adopt	Adopt
YEAR	2011	2012	2013	2014	2015
2011	\$18,000	\$0	\$0	\$0	\$0
2012	\$12,000	\$18,000	\$0	\$0	\$0
2013	\$8,000	\$12,000	\$15,000	\$0	\$0
2014	\$4,000	\$8,000	\$12,000	\$15,000	\$0
2015	\$2,000	\$4,000	\$8,000	\$12,000	\$0
2016	<u>\$0</u>	<u>\$2,000</u>	<u>\$4,000</u>	<u>\$8,000</u>	<u>\$0</u>
Total	\$44,000	\$44,000	\$39,000	\$35,000	\$0

INCENTIVES – RURAL CLINIC

RURAL CLINIC					
	Adopt	Adopt	Adopt	Adopt	Adopt
YEAR	2011	2012	2013	2014	2015
2011	\$25,000	\$0	\$0	\$0	\$0
2012	\$10,000	\$25,000	\$0	\$0	\$0
2013	\$10,000	\$10,000	\$25,000	\$0	\$0
2014	\$10,000	\$10,000	\$15,000	\$25,000	\$0
2015	\$10,000	\$10,000	\$10,000	\$10,000	\$0
2016	\$0	\$10,000	\$10,000	\$10,000	
Total	\$65,000	\$65,000	\$65,000	\$33,750	\$0