Meaningful Use Stages I and II and the Challenges Facing Us

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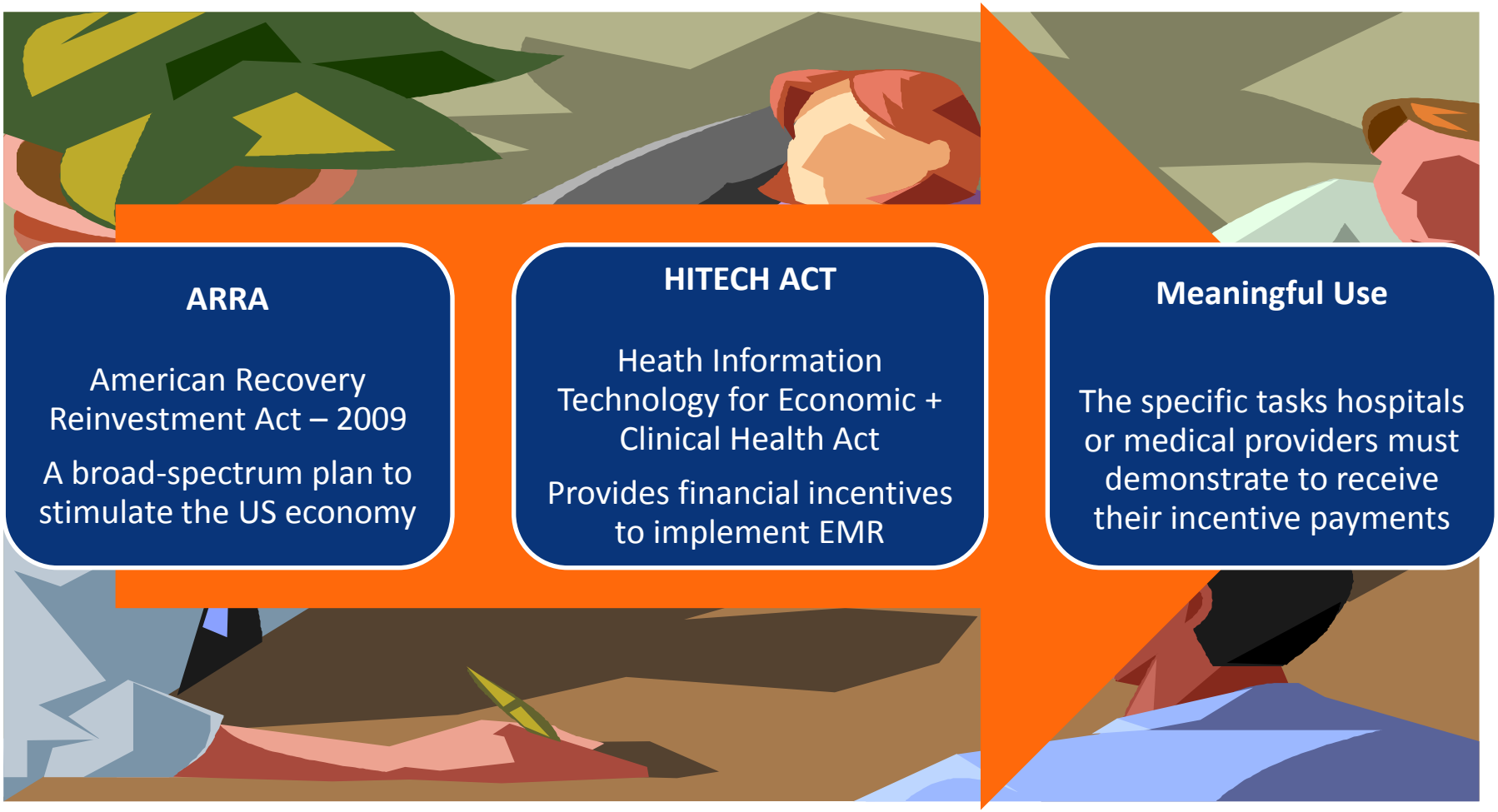
How did we get here……

Healthcare – How Did We Get Here…



Intention is to stimulate, incentivize and develop a foundation in order to drive improved patient outcomes

ARRA → $787 Billion and $50 + Billion for HIT

One Hundred Eleventh Congress
of the
United States of America

AT THE FIRST SESSION

Begun and held at the City of Washington on Tuesday, the sixth day of January, two thousand and nine

An Act

Making supplemental appropriations for job preservation and creation, infrastructure investment, energy efficiency and science, assistance to the unemployed, and State and local fiscal stabilization, for the fiscal year ending September 30, 2009, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the "American Recovery and Reinvestment Act of 2009".

ARRA Overview American Recovery & Reinvestment Act

HIMSS Central & Southern Ohio Chapter — transforming healthcare through IT

Appropriations for Health IT

$2 billion for loans, grants & technical assistance for:

- National Resource Center and Regional Extension Centers
- EHR State Loan Fund
- Workforce Training
- Research and Demonstrations

Appropriations for Health HIE

<u>At least</u> $300 million of the total at HHS Secretary's discretion for HIE development

- Funneled largely through States or qualified State-designated entities
- For planning and/or implementation

New Incentives for Adoption

New Medicare and Medicaid payment incentives for HIT adoption

- $20 billion in expected payments through Medicare to hospitals & physicians
- $14 billion in expected payments through Medicaid
- ~$34 billion expected outlays, 2011-2016

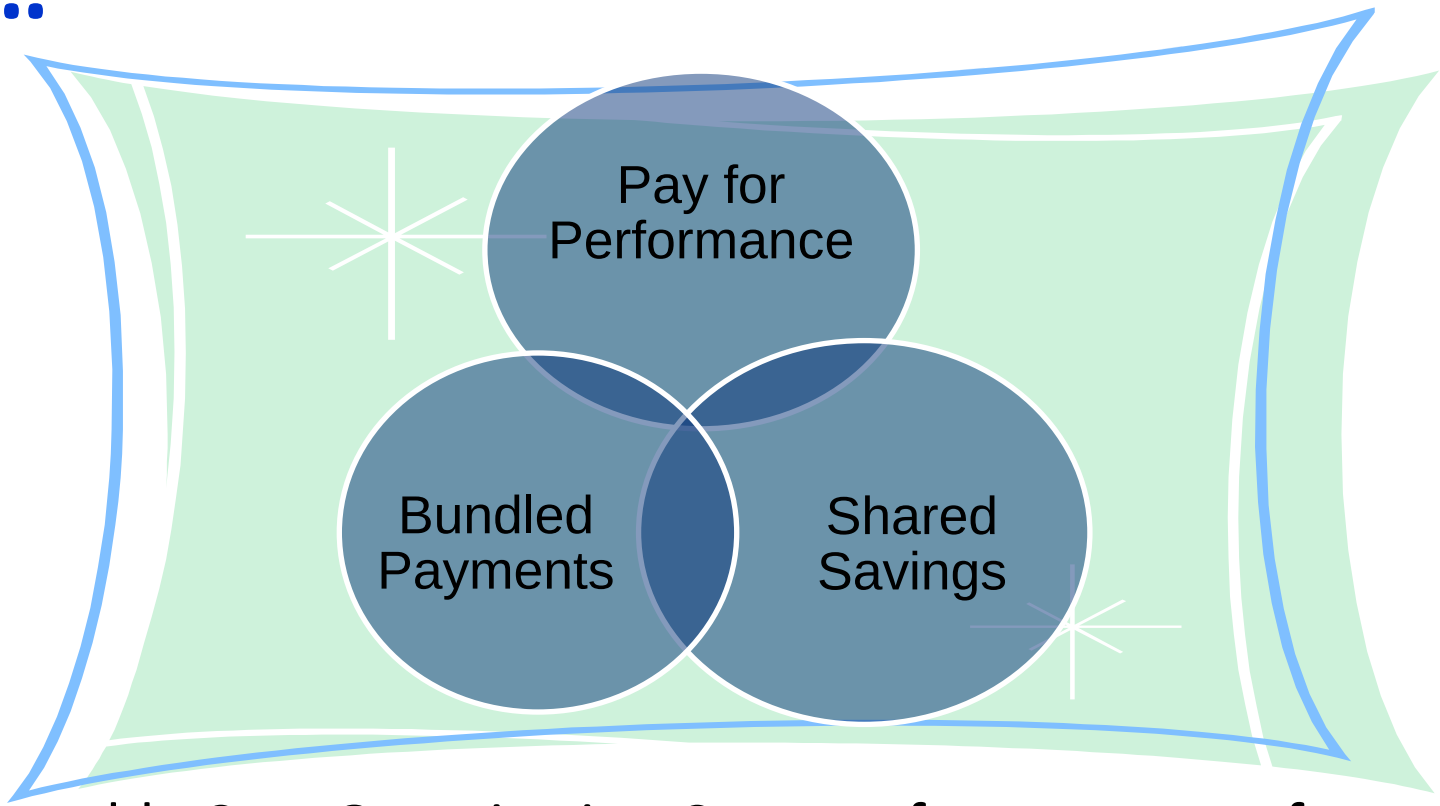
Community Health Centers

$1.5 billion in grants through HRSA for construction, renovation and equipment, including acquisition of HIT systems

Broadband and Telehealth

$4.3 billion for broadband & $2.5 billion for distance learning/ telehealth grants

Healthcare – At the Same Time…



The Accountable Care Organization Concept focuses on performance and utilization of care. Pay one time for a procedure/service (bundled payment), pay for high quality and good patient experience (P4P), and if an organization is highly efficient, share in the cost savings. This is a totally different reimbursement model from today.

Healthcare – What's On Your Mind…

CEO	CMO/CNO	CFO	CIO
Physician & Clinician Integration	Physician & Nursing Shortage	Declining Revenue	Meaningful Use Achievement
Healthcare Reform	Clinical Transformation	Increasing Costs	CPOE & Clinical Documentation
Meaningful Use	Clinical Strategy Standardization	Profit/Margin	EHR Implementation
Capital & Bond Ratings	Patient Safety	Labor Expense & Inefficient Processes	HIE
ACO's	Reduction in Errors	Bundled Payments Impact	Integration
Financial Risks	Increase Quality of Care and Operational Efficiency	Regulatory Demands & Impact to Capital	Shortage of Talent
Cost Containment & Layoffs	CPOE Implementation & Clinical Documentation	Bond Ratings	Demand Greater Supply
Profit/Margins	EMR Implementation & Risk Mitigation	Access to Cash/Capital	Data Warehousing & Reporting
Bundled Payments	Clinical Dashboards	Changing Case Mix and Impact to Revenue	ICD-10 Implementation
Board Approvals	Physician Profiles	ICD-10 Risk Mitigation	

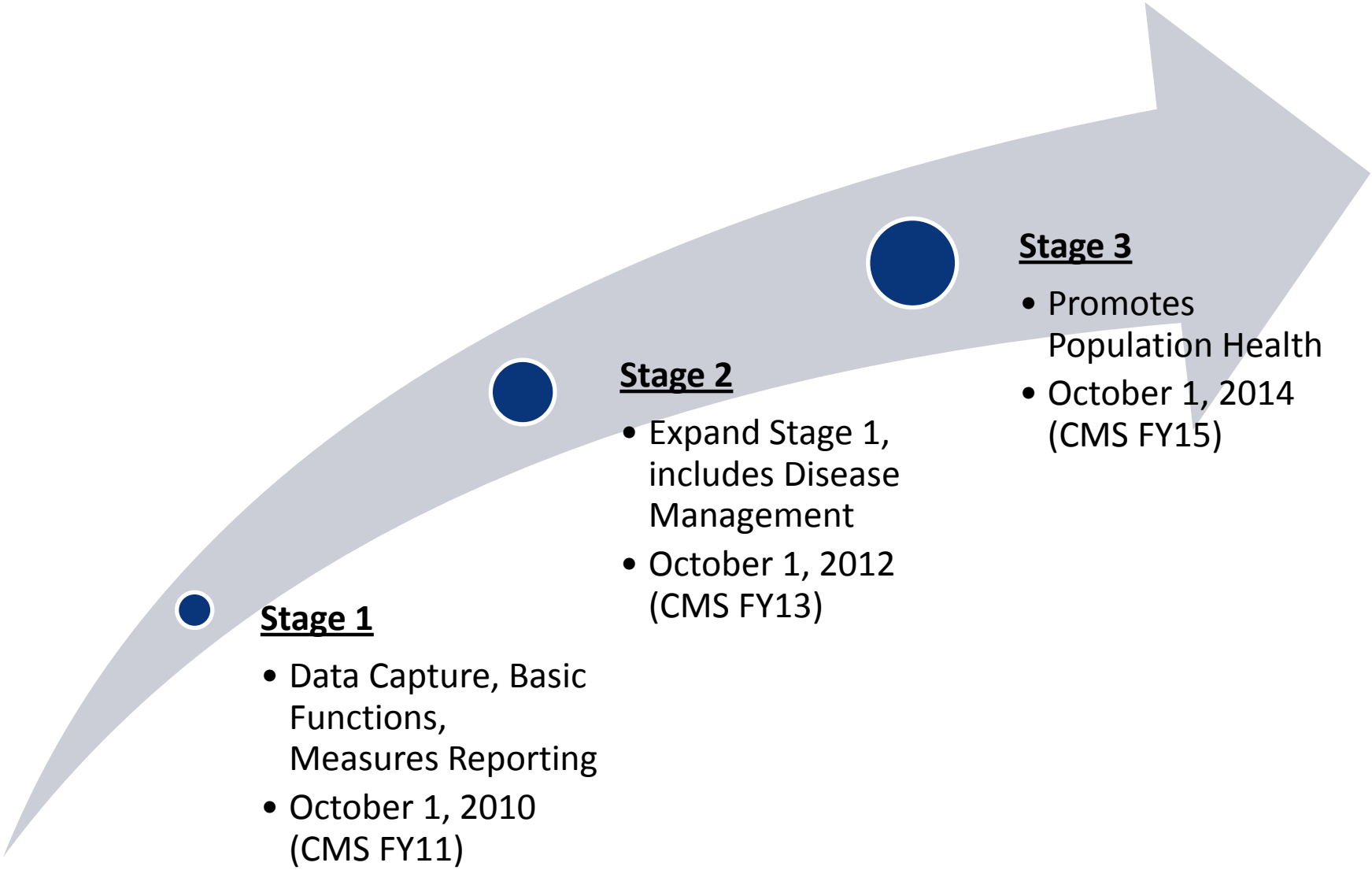
Healthcare – Who's On First…

- Organizations Driving Quality Metrics
  - ARRA/Meaningful Use
  - Joint Commission/CMS Core Measures
  - National Quality Forum
  - Physician Quality Report Initiatives (PQRI)
  - National Database of Nursing Quality Indicators (NDNQI)
  - HEDIS
  - Leapfrog
  - AHRQ

Purpose of Meaningful Use

- Improve Quality, Safety, Efficiency and Reduce Healthcare Disparities
- Engage Patients and Families
- Improve Care Coordination
- Ensure Adequate Privacy and Security Protection for Personal Health Information
- Improve Population and Public Health

The Three Stages of Meaningful Use



Stage 1

- Data Capture, Basic Functions, Measures Reporting
- October 1, 2010 (CMS FY11)

Stage 2

- Expand Stage 1, includes Disease Management
- October 1, 2012 (CMS FY13)

Stage 3

- Promotes Population Health
- October 1, 2014 (CMS FY15)

Three Guiding Principles To Meet Meaningful Use

Three Components:

- Use of Certified EHR in a Meaningful Manner
- Use of Certified EHR Technology for Electronic Exchange of Health Information to Improve Quality of Healthcare
- Use of Certified EHR Technology to Submit Clinical Quality and Other Measures

Overview: Health IT Incentives and Support for Adoption

- The Medicare and Medicaid Health IT provisions in the Recovery Act provide incentives and support for the *adoption of certified electronic health records (EHRs)*
- The Recovery Act authorizes bonus payments for eligible professionals and hospitals participating in Medicare or Medicaid if they become *meaningful users of certified EHRs*
- The incentive bonuses will begin in 2011. Beginning in 2015, the Recovery Act mandates penalties under Medicare for eligible professionals and hospitals that *fail to demonstrate meaningful use of certified EHRs*
- Patient Privacy and Security are an important part of Health IT. HHS Office of Civil Rights, CMS and ONC are working on privacy/security provisions

Meaningful Use Stage 1 Requirements

- EPs (Ambulatory, Out-patient)
  - 25 Objectives and measures
  - 8 Measures require 'Yes' / 'No' as structured data
  - 17 Measures require numerator and denominator
  - 6 Total Clinical Quality Measures (3 Core or Alternate Core, 3 from a Menu set of 38)
- Eligible Hospitals and CAHs
  - 23 Objectives and measures
  - 10 Measures require 'Yes' / 'No' as structured data
  - 13 Measures require numerator and denominator
  - 15 Clinical Quality Measures
- Reporting Period: any continuous 90-day period within first reporting year, entire year for all subsequent years afterwards

Meaningful Use Challenges

- Inter-Professional, Collaborative Patient-Centered Care
- Workflow & Hand-Off Issues
- Effective Use of Technology
- Change Management
- Evidence-Based Content Programs
- Quality Improvement Programs
- Adoption of Technology
- And….

In the sea of denominators we need to find the…

Numerator……

Are you worried.. I am

Is our project portfolio aligned with the business needs for ACO and MU?

Are we meeting our MU & reporting commitments?

What will be the impact if we miss our next MU milestone?

What Quality Improvement Initiative do we do first?

Are we at risk for not achieving our fiscal year strategic initiatives?

Can we absorb the penalties of not achieving MU?

Can we take on these strategic projects? What will it cost? How long will it take?

How do we align incentives to get the results we need?

How do we manage two different reimbursement models?

We have to streamline and cut cost? We don't have years to do this. How can we do it quickly and effectively?

Do we have the right team in place to lead us to the next level of healthcare?

Timelines, ACOs and Stage II…

Time Lines….

- 1/1/2011 - Stage 1 ARRA MU begins with proof by attestation for at least 90 consecutive days
- 1/1/2012 - Stage 1 ARRA MU to be confirmed by direct electronic reporting
- 1/1/2012 - Move from 4010 to 5010 transaction codes
- 1/1/2012 - Enabling regulations clear the way for ACOs scheduled to become law

Timeline cont…

- November 2012 - National Elections
- January 2013 - Stage 2 ARRA
- October 2013 - Move to ICD-10
- 2014 - Many eligibility reforms take effect
- January 2015 - Stage 3 ARRA

Timeline cont…

- 2015 - Penalties for Medicare MU non-compliance begin
- November 2016 - National election
- 2016 - Last year to apply for Medicaid MU

ACOs

It is highly likely that the current federal administration - with the Medicare and Medicaid programs - is going to use the momentum of the new health insurance reform legislation to address the broken and costly health care delivery system. This was indicated by President Obama's nomination of Donald M. Berwick

He is a leading proponent of a health care vision called the "Triple Aim" saying that new health care initiatives should improve the experience of care, improve the health of populations, and reduce per capita costs of health care.

…we are likely to see a movement away from fee-for-service models to accountable care organizations (ACOs) supported by primary care or patient-centered medical homes (PCMHs)

Jay Pomerantz, MD

Harvard Medical School

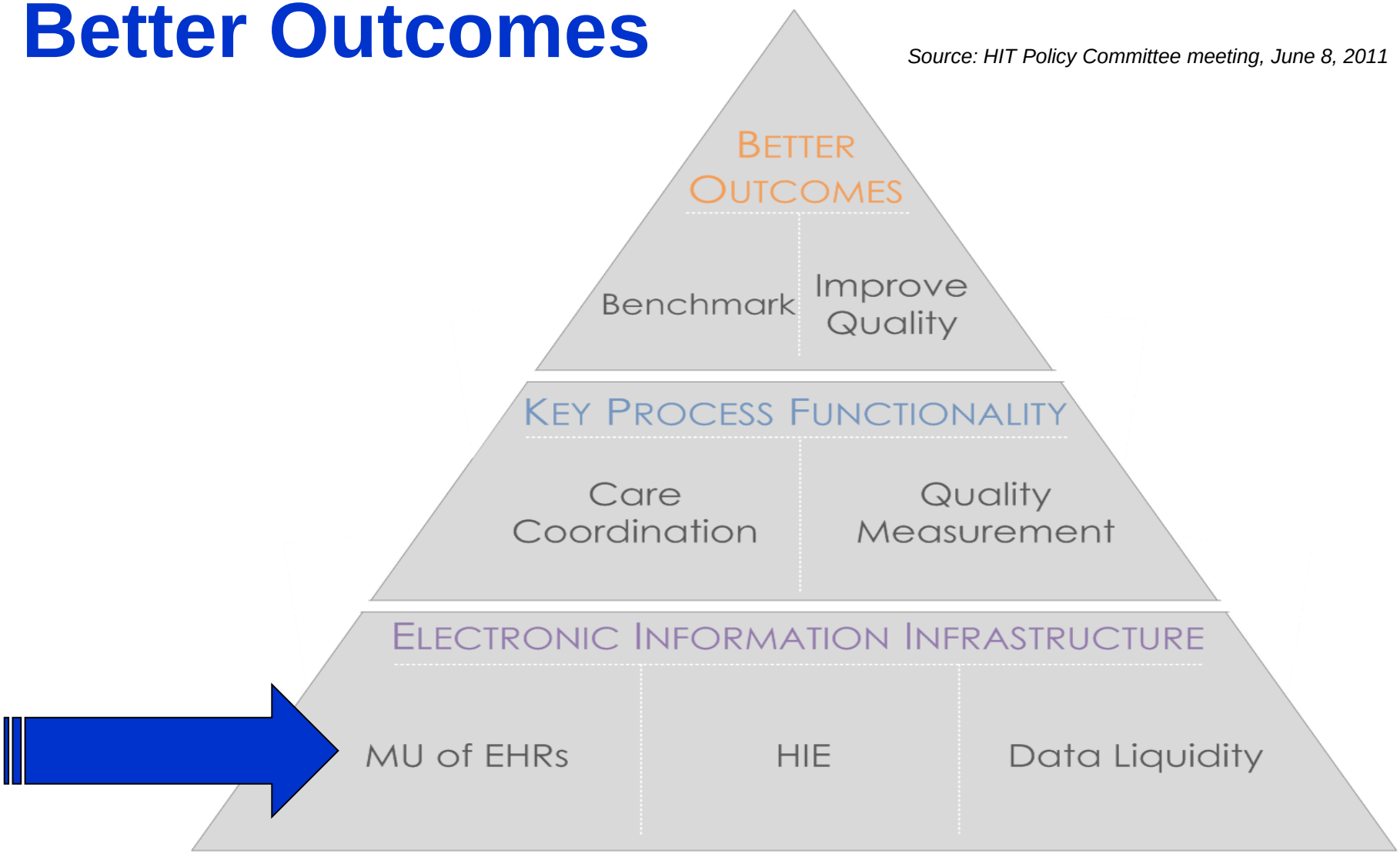
Delivery Systems to ACOs?

From S.M. Shortell, L.P. Casalino, and E.S. Fisher

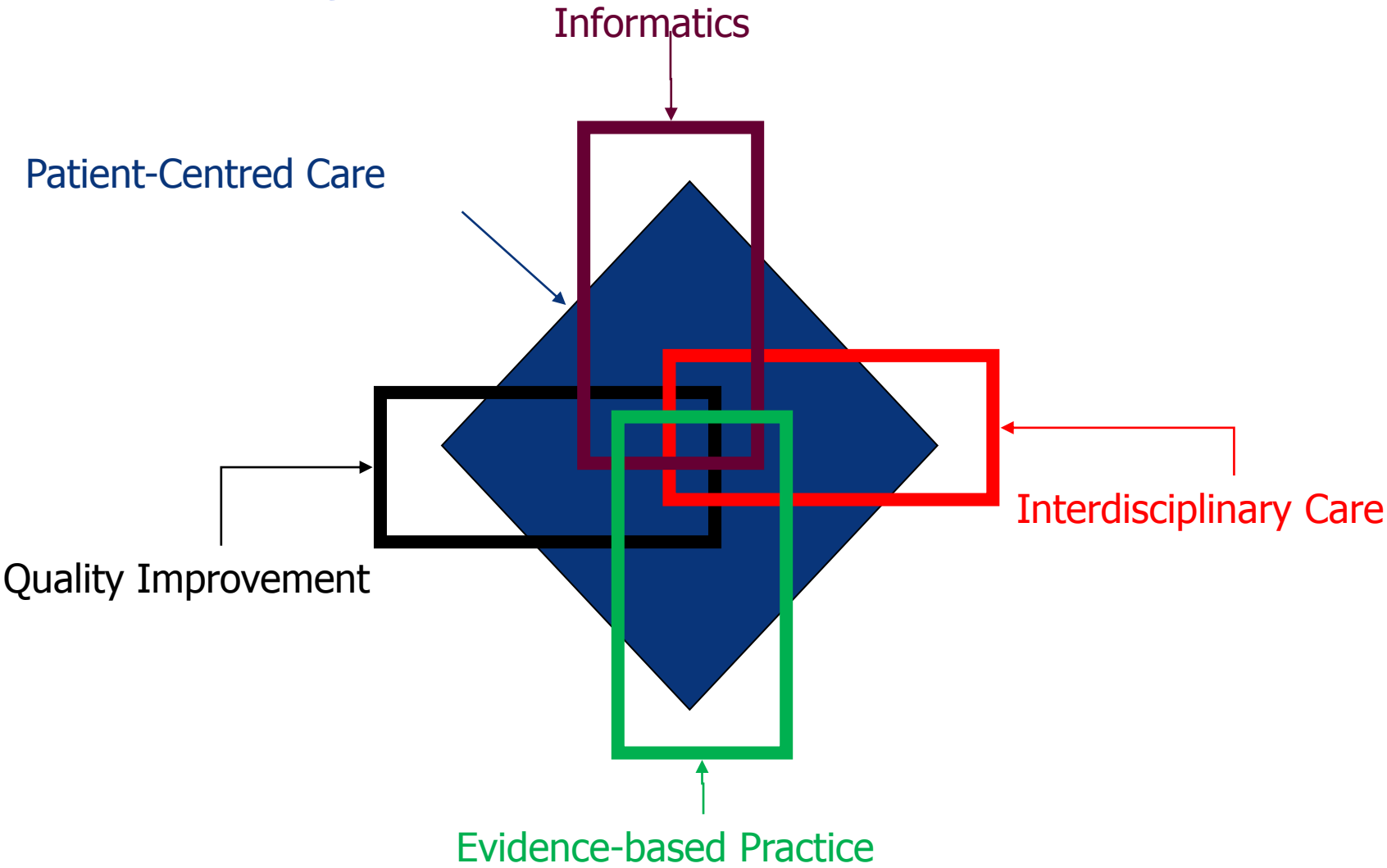
Model	Characteristics	Current Examples
Integrated delivery systems	Own Hospitals, physicians, Practices, perhaps insurance plan Aligned financial incentives, EHR, team based care	Geisinger Health System Group Health Cooperative of Puget Sound Kaiser Permanente
Multi-specialty group practice	Usually own or have affiliation with a hospital Contracts with multiple health plans History of MD leadership Mechanisms for coordinated care	Cleveland Clinic Marshfield Clinic Mayo Clinic Virginia Mason Clinic
Physician-hospital org.	Non-employed MD staff Functions like Multi-Specialty group Reorganize care delivery for cost-effectiveness	Advocate Health (Chicago) Middlesex Hospital (Conn) Tri-State Child Health Services (Cincinnati)
Independent Practice Assoc. (IPAs)	Independent physician practices that jointly contract with health plans Active in practice redesign, QI	Atrius Health (Mass) Hill Physician Group (SoCal) Monach Health Care (SoCal)
Virtual Physician Organizations	Small IPA's often rural Led by Individual MD's, local medical foundation or state Medicaid Agency Structure to provide leadership, infrastructure for redesign	Community Care of N. Carolina Grand Junction (Colorado) North Dakota Cooperative Network

EHR Core Functionality Lays the Foundation for Better Outcomes

Source: HIT Policy Committee meeting, June 8, 2011



IOM Core Competencies… how do they fit?



Phasing of MU Criteria: A Balancing Act

- Urgency of Reform
- Outcomes Improvement

- Currently available EHR capabilities
- Time needed to implement
- Small practice realities…. dollars, resources, ability to absorb change

Availability of technical assistance and exchange capability

Some are asking is it worth the penalties that will start in 2015…..

The Congressional Budget Office estimates a cost of $25,000 - $40,000 per provider for EHR implementation in a physician's office and an average cost of $14,500 per bed for the implementation of CPOE in a hospital setting.

Evidence on the Costs and Benefits of Health Information Technology. Congressional Budget Office

We aren't even through Stage I and here comes Stage II

- Some Key Principles that SHOULD Drive Stage 2 Recommendations
  - Alignment of Meaningful Use (MU) objectives with National Quality Strategy priorities
  - Ensure MU lays adequate HIT infrastructure to achieve delivery system changes required for Affordable Care Act (ACA) reforms
  - We need to be sure we can support the plan from both a technical and an implementation standpoint
  - We should be sure the timeline encourages and rewards early adopters versus jeopardize their potential for long term success

HIT Policy Committee Recommendations on Stage 2 Timing

- The proposal is to defer Stage 2 by one year for Eligible Hospitals (EHs) and Eligible Professionals (EPs) that qualify for meaningful use in the 2011 payment year.
- Since the final rule on Stage 2 is not expected until mid-2012, early adopters (particularly hospitals) would have only a few months between knowing the final Stage 2 requirements and be responsible for actually meeting them.
- Under the current schedule, providers/hospitals who attest to meeting 90 days of Stage 1 during 2011 are responsible for a full year of Stage 1 in 2012, followed by a full year of Stage 2 in 2013.
- EHs are based on Federal Fiscal Year, EPs on calendar year

What *might be* in store for MU Stage II

CORE SET - All are required					
Stage 1 Objectives	**EP**	**EH**	**Stage 1 Measurement**	**Stage II Proposal**	**Change**
Problem List	Y	Y	80%	No change	No change
Active Medication List	Y	Y	80%	No change	No change
Active Allergy List	Y	Y	80%	No change	No change
CPOE	Y	Y	30%	Increase threshold to 60% for med orders and add one lab and one radiology order for > than 60% of patients	Increased threshold % and new criteria added
Drug/Drug & Drug/Allergy Checking	Y	Y	Enabled for entire reporting period	Provide the ability to refine the alerts	New criteria added

What *might be* in store for MU Stage II

CORE SET - All are required					
Stage 1 Objectives	**EP**	**EH**	**Stage 1 Measurement**	**Stage II Proposal**	**Change**
ePrescribing	Y	Y	40% of eligible prescriptions	Increase to 50% for OP med orders Add 10% of all hospital discharge med orders	Increased threshold % and new criteria
Demographics: Language, gender, race, ethnicity, DOB and for EHs - preliminary cause of death)	Y	Y	50%	Increase threshold to 80% and must be able to run stratified reports	Increased threshold % and new criteria added
Vital Signs (height, weight, B/P, BMI, growth chart for ages 2-20)	Y	Y	50% for age 2 and over	Increase threshold to 80% and increase age for recording B/P to 3 years of age	Increased threshold % and criteria modified

What *might be* in store for MU Stage II

CORE SET - All are required					
Stage 1 Objectives	**EP**	**EH**	**Stage 1 Measurement**	**Stage II Proposal**	**Change**
Record smoking status for patients 13 years old or older	Y	Y	50%	Increase threshold to 80%	Increased threshold %
Clinical Decision Support Rule	Y	Y	Implement one clinical decision support rule and track compliance to the rule	Use Clinical Decision Support rule to improve performance	Criteria modified
CQM Reporting	Y	Y	Report clinical quality measures through attestation	Report clinical quality measures electronically	Criteria modified
Protect electronic health information	Y	Y	Conduct or review a security risk analysis implement security updates as necessary	Conduct or review a security risk analysis implement security updates as necessary	New criteria added

What *might be* in store for MU Stage II

CORE SET - All are required					
Stage 1 Objectives	**EP**	**EH**	**Stage 1 Measurement**	**Stage II Proposal**	**Change**
Drug Formulary Check	Y	Y	MENU Implement drug formulary checks	CORE No other change	Move to core
Advanced Directives	Y	Y	MENU Record presence of Advance Directive for 50% of all patients 65 yrs and older	CORE Record for 50% of all EH patients and 25% of EP patients age 65 and older including date & timestamp and have access if one exists.	Move to core and new criteria added
Structured clinical lab results	Y	Y	MENU 40% of time incorporate structured clinical lab test results	CORE Use LOINC where available	Move to core and new criteria added

What *might be* in store for MU Stage II

CORE SET - All are required					
Stage 1 Objectives	**EP**	**EH**	**Stage 1 Measurement**	**Stage II Proposal**	**Change**
Patient report by specific condition	Y	Y	MENU Generate at least one report listing patients by specific conditions	CORE Generate patient lists for multiple patient specific parameters	Move to core and criteria modified
Patient Education	Y	Y	MENU 10% of patients are provided patient-specific education resources	CORE 10% of all patients are provided with EHR enabled patient specific education resources.	Move to core and criteria modified
Medication Reconciliation	Y	Y	MENU 50%	CORE No change	Move to core with no change

What *might be* in store for MU Stage II

CORE SET - All are required					
Stage 1 Objectives	**EP**	**EH**	**Stage 1 Measurement**	**Stage II Proposal**	**Change**
Transition of Care	Y	Y	MENU Summary of Care record done for 50% of patients being transitioned to other care settings	CORE EH -->10% of all discharges have summary and care plan sent electronically to EP or post acute care facility EP --> at least 25 summary of care transactions sent electronically	Move to core and criteria modified
Immunization Data	Y	Y	MENU One electronic test submission to the state immunization registry has been completed	CORE Submit immunization data in accordance with law and practice	Move to core and criteria modified

What *might be* in store for MU Stage II

CORE SET - All are required					
Stage 1 Objectives	**EP**	**EH**	**Stage 1 Measurement**	**Stage II Proposal**	**Change**
Patient Reminders	Y	N/A	MENU 20% of all unique patients 65 years or older or 5 years old or younger were sent an appropriate reminder	CORE 10% of all active patients are sent a clinical reminder (existing appointment reminders do not count)	Move to core and criteria modified
Patient is granted timely electronic access to their health information	Y	N/A	MENU 10% of patients seen by the EP are provided timely electronic access to their health information	CORE 10% of patients/families have the ability to view and download their longitudinal health information within 24hrs of an encounter (or within 4 days for pending info)	Move to core and criteria modified

What *might be* in store for MU Stage II

CORE SET - All are required					
Stage 1 Objectives	**EP**	**EH**	**Stage 1 Measurement**	**Stage II Proposal**	**Change**
Syndromic Health Info	N/A	Y	MENU One electronic test submission to the state syndromic registry	CORE Submit syndromic surviellance data in accordance with law and practice	Move to core and criteria modified
Electronic copy of discharge instructions	N/A	Y	MENU 50% of discharges	80% of patients who are being discharged are offered and electronic copy	Increased threshold % and criteria modified
Clinical Visit Summary	Y	N/A	50%	Clinical visit summaries provided for 50% of patients within 24hrs and pending information (IE labs) available within 4 days	Criteria modified

What *might be* in store for MU Stage II

CORE SET - All are required					
Stage 1 Objectives	**EP**	**EH**	**Stage 1 Measurement**	**Stage II Proposal**	**Change**
Capability to submit electronic data on reportable lab results	N/A	Y	MENU One electronic test submission to the state public registry	CORE Submit structured lab data in accordance with law and practice to at least one practice	Move to core and criteria modified
	Y	Y	N/A	List of care team members (including PCP when available) available for 10% of patients via electronic exchange	New
	Y	Y	N/A	30% of all EP visits and 30% of EH patient days have at least one electronic note by a Physician, NP or PA (non-searchable, scanned notes do not qualify)	New

What *might be* in store for MU Stage II

CORE SET - All are required					
Stage 1 Objectives	**EP**	**EH**	**Stage 1 Measurement**	**Stage II Proposal**	**Change**
	N/A	Y	N/A	Hospital Labs to send structure electronic clinical lab results to outpatient providers for > 40% of electronic orders received using LOINC where available	New
	N/A	Y	N/A	EH medication orders automatically tracked via an eMAR on at least one hospital unit (automatically implies all 5 rights are recorded without manual transcription)	New

What *might be* in store for MU Stage II

CORE SET - All are required					
Stage 1 Objectives	**EP**	**EH**	**Stage 1 Measurement**	**Stage II Proposal**	**Change**
	N/A	Y	N/A	EH --> 10% of patients/families have the ability to view and download information about a hospital admission within 36 hours of an encounter	New
	Y	N/A	N/A	Patients are offered online secure messaging and at least 25 patients have sent secure messages	New
	Y	N/A	N/A	Patient preference for communication medium is recorded for 20% of patients	New

What *might be* in store for MU Stage II

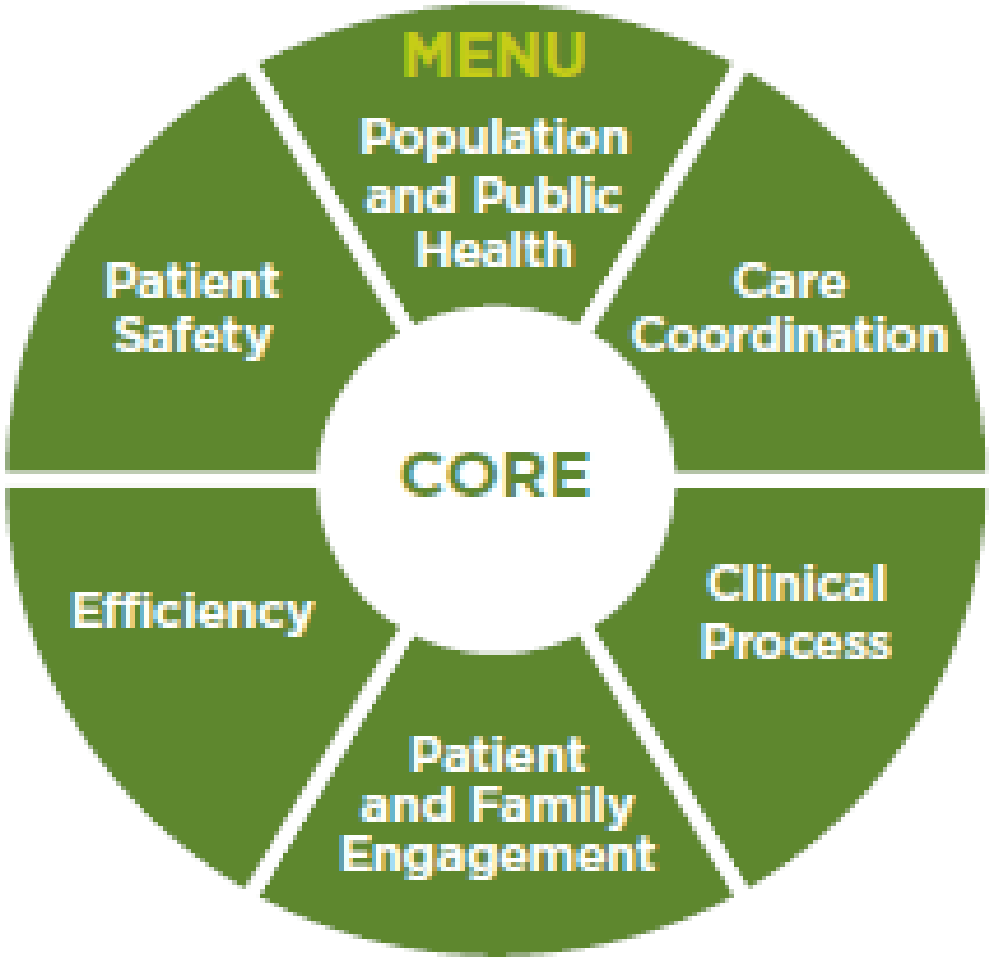
CORE SET - All are required					
Stage 1 Objectives	**EP**	**EH**	**Stage 1 Measurement**	**Stage II Proposal**	**Change**
	Y	N/A	N/A	Submit reportable cancer conditions in accordance with applicable law and practice	Being considered
Provide patients with an electronic copy of their health information	Y	Y	50% of patients who request an electronic copy are provided it	Combined with other objectives	Eliminated
Electonic exchange of key clinical info (CCD)	Y	Y	One test performed of certified EHR technology's capacity to electronically exchange key clinical information	Eliminated due to new proposed measures	Eliminated

What *might be* in store for MU Stage II – the CQMs

- Providers would report on some number (proposal is between 5 and 10) of the core measures
  - The core quality measure set would include all of the core and alternate core measures from Stage 1 and an additional 2 measures related to care coordination
  - Currently there is no mention of establishing required thresholds to be met on any of the quality measures.
- And at least one measure from each of 6 menu "domains" that are aligned with the National Quality Strategy

What *might be* in store for MU Stage II – the CQMs

Source: HIT Policy Committee meeting, June 8, 2011



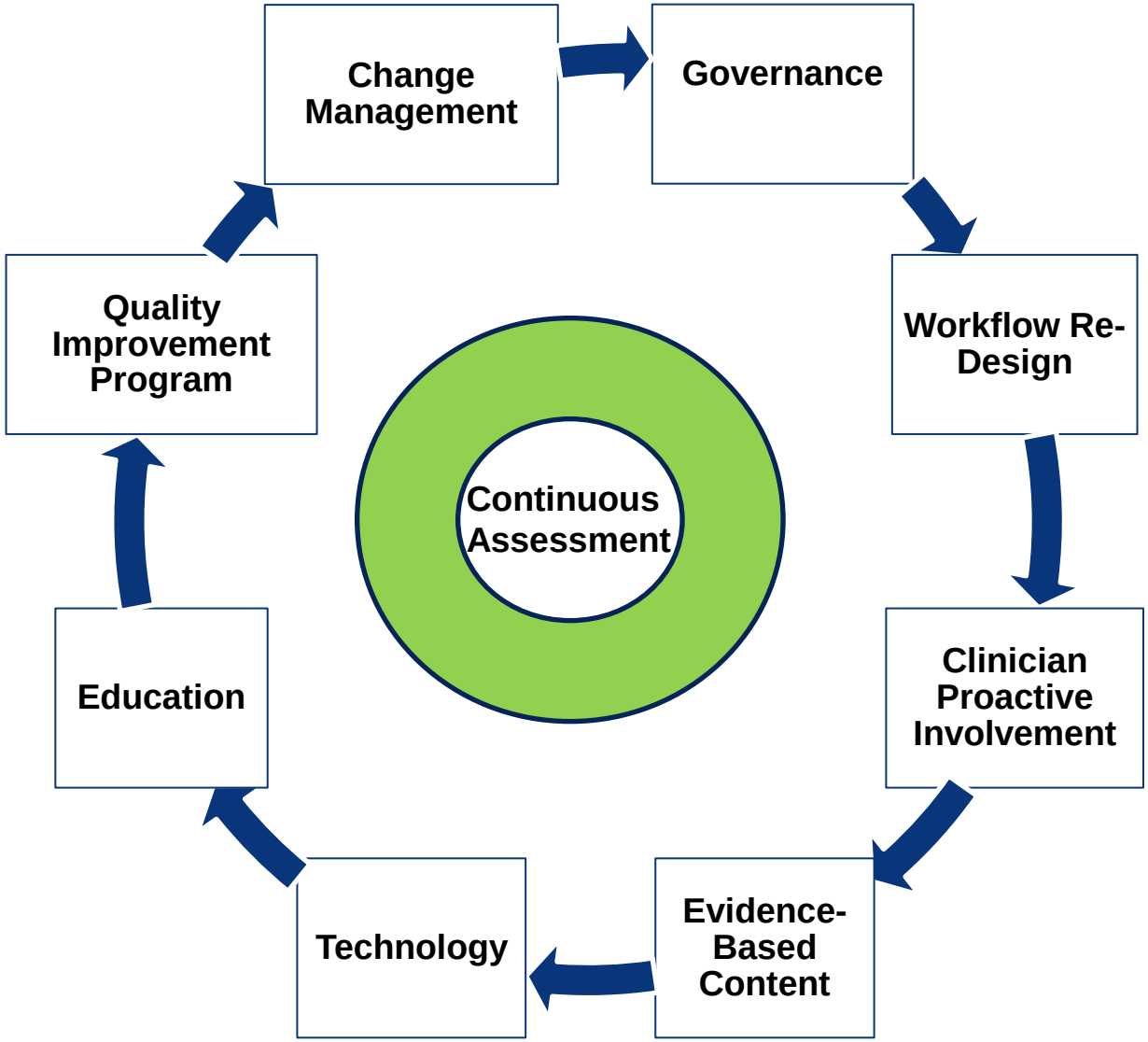
"Domains" correspond to the National Quality Strategic Priorities

How do we ensure success…

Case Studies

	Academic Multi-Hospital Organization	Large Multi-Hospital Organization	Small Multi-Hospital Organization
Governance			
Workflow Re-Design			
Clinician Involvement			
Evidence Based Content			
Technology			
Education			
Quality Improvement			
Change Management			
Continuous Assessment			

What Really Works



Integration of Clinical Workflow into MU Success

- Research has concluded that adoption and integration of EHR technology requires the successful integration of health information technology (HIT) into clinical workflow.
- The implementation of these new technologies and workflows must occur on top of other organizational initiatives and costs can be enormous.
- Emphasis has been placed on the adoption of a national health information exchange network by 2014
- For success adoption of software and technology, changes and decisions must not be driven or made by IT

Integration of Clinical Workflow into MU Success

- During evaluation and changes to workflow we must ensure we don't lose our focus on patient safety, enhancing the quality of our patient data and improving efficiency of workflow
- Change management must be a collaborative effort among EHR champions and clinical staff.
- Utilizing workflow assessments and workflow diagrams steps can be taken to mitigate the disruption to workflow and productivity that can occur during the implementation of EHR technology.

Integration of Clinical Workflow into MU Success

- The dynamics of the leadership team can have a huge impact on the integration and implementation of new EHR technology. Prior to the process starting, it is imperative that the desired message be communicated to the entire organization and that the leadership team is held accountable for assessing areas of discord and responding as appropriate

- It is imperative to recognize the concerns and challenges being brought forth by the clinical staff and whenever appropriate their comments and feedback should drive the strategies to ensure productivity remains high and the workflow remains efficient

Ensuring High Quality Transitional Care…

"Complex problems are rarely remedied by simple solutions. Improving the quality of transitional care is no exception as there are no quick fixes. Rather our response will require a multifaceted approach; the centerpiece will feature a renewed commitment to patient centered care and establishment of effective cross setting communication and collaboration. Improving quality and safety during care handovers is fundamentally different from improving quality or safety in single setting"

Eric A. Coleman, MD, MPH
Director, Care Transitions Program
University of Colorado Denver

Some key elements to successfully reaching your Meaningful Use Stage I & II goals

1. Continuously keep an eye on how you are doing against Stage I
2. Remember… the Stage One Menu items will most likely become Core elements
3. Do CPOE the right way (ensure your compendiums or orders catalogs are physician friendly etc) so your Providers are ready to enter all orders….
4. Start thinking now about a Patient Portal.
5. Engage your HIPAA and Privacy officer early as there is a lot of security angst anytime we talk about access into Patient Info.

Some key elements to successfully reaching your Meaningful Use Stage I & II goals

5. Stay in close contact with your vendor
6. Become engaged in your state HIE and REC programs. Participating will eventually become a MU objective and early engagement ensures you have a voice and are ready.
7. Keep an eye on all Quality 'bodies'… the goal is alignment and we will need to be nimble to meet not only the MU measures but those of other payers
8. Never lose sight of the HITECH, HIPAA, Security & Privacy regulations. While there is nothing definitive appearing in Stage II it doesn't mean changes aren't coming.

What's happening around us…

National Quality Strategic Priorities and how they tie to MU

- Make care safer by reducing harm caused in the delivery of care
  - ↑ CPOE definitions and thresholds
  - Require use of an eMAR
  - ↑ requirements for Medication Reconciliation
  - Develop safety related CQMs
  - Require eRX for all scenarios

- Ensure patients & families are engaged in their care
  - Record and ensure accessibility to Advanced Directives
  - Secure Messaging
  - Record and use patient's preference for communication
  - ↑ thresholds for use of Patient Reminders

National Quality Strategic Priorities and how they tie to MU cont.

- Promote effective communication and coordination of care
  - Require state development and use of HIE
  - Longitudinal care plans
  - Sharing of summary of care records
  - Electronic progress notes that are searchable
  - Care Coordination CQMs

- Promoting the most effective prevention and treatment for the leading causes of mortality
  - Use of patient registries
  - Generation and monitoring of patient lists with specific clinical conditions
  - ↑ the use and appropriateness of patient specific education

National Quality Strategic Priorities and how they tie to MU cont.

- Work with communities to promote healthy living
  - Increase in public health objectives

- Make quality care more affordable for individuals, families, employers and governments by developing and spreading new healthcare delivery models
  - Use of drug formulary checking for eligibility for payment
  - Use of Clinical Decision Support rules and algorithms to reduce redundancy in testing

Various Initiatives…Adoption, Telehealth, Research, Cost/Benefit Studies, Quality & Safety, HIEs

- ***Vermont* - Improving Healthcare Quality via Information Technology**
  - Implements an integrated electronic patient medical record, electronic medication administration record, computerized physician order entry, and clinical decision support software that will be accessible at all participating facilities which include an acute care hospital, home health care agency, ambulatory clinics, a rehab facility, and to the patient/resident from home. Surveys suggest that staff notions of patient safety have indeed evolved in particular ways that mirror the efforts of administration to promote improved communication, standardization of clinical practice, the use of IT, and the promotion of a "culture of safety" throughout the organization.

Various Initiatives…Adoption, Telehealth, Research, Cost/Benefit Studies, Quality & Safety, HIEs

- ***Pennsylvania* - St. Luke's-Miners Hospital, AHRQ Health IT Portfolio - Diabetes Patients in Rural Pennsylvania Benefit from New Technologies**
  - For rural diabetes patients, particularly those who are elderly, visits to endocrinologists can involve long, costly, and exhausting trips to distant offices in larger cities. Yet with a condition like diabetes, which requires constant monitoring of symptoms, such consultations are vitally important. A new Pennsylvania Telehealth system is seeking to solve this dilemma by giving diabetic patients access to quality care while allowing them to remain closer to their homes. Through videoconferencing technologies, the program, based at St. Luke's-Miners Hospital, connects area diabetic patients to specialists in some of Pennsylvania's larger cities.

Various Initiatives…Adoption, Telehealth, Research, Cost/Benefit Studies, Quality & Safety, HIEs

- ***Maryland* - Receives Final Approval of Startup Funds for Health Information Exchange**
  - In 2008, the Maryland Health Care Commission issued an award to begin the development of a blueprint of a "consumer-centric" private and secure health information exchange. Essentially, patients would have control of their medical data being shared. Since then, funding has been approved. According to *Healthcare IT News, Maryland State officials* recently announced, the approval of up to $10 million in startup funding for the Chesapeake Regional Information System (CRISP), a non-profit membership corporation made up of state healthcare stakeholders. The startup funding will come from hospital reimbursement rate adjustments, and will be dispersed over the next two to five years to help build the health information exchange.

Healthcare IT News

HIMSS Central & Southern Ohio Chapter

transforming healthcare through IT

Competition seeks care transition, adverse events apps

By *Molly Merrill, Associate Editor*

Created *09/13/2011*

SAN FRANCISCO – Health 2.0 and ONC on Monday launched competitions to develop new health IT apps aimed at easing the transition from hospital to home and reporting medical device adverse events.

The competitions, which are now open for submissions, are part of the Investing in Innovation Initiative (i2) and are managed by Health 2.0 through its Health 2.0 Developer Challenge program.

"The i2 initiative is ONC's first step into the health IT market using the model of combined private and public sector engagement to foster innovative technology development," said Wil Yu, special assistant of innovations and research at ONC. "Our team will identify the challenges and goals of i2 and let the market – the innovators and entrepreneurs – uncover new ways to address the most critical issues within the healthcare industry."

Nuance Communications, Inc. and IBM, announced that the companies are working together to advance the state-of-the-art in Clinical Language Understanding (CLU) technologies that will enable healthcare organizations to understand and utilize the unstructured clinical information contained in the more than two billion patient reports dictated every year in the U.S. alone.

With the goal of transforming healthcare clinical documentation through advanced technologies, Nuance and IBM are developing systems that will automatically extract and convert discrete clinical data from clinician-dictated narrative into actionable information that can be used to bring a more evidence-based approach to patient care.

With these advanced CLU technologies integrated into Nuance's suite of front-end and back-end speech recognition solutions, clinicians will be empowered to document via speech recognition into the EHR knowing a CLU-enhanced system can process, identify and extract important clinical data elements such as problems, social history, medications, allergies, and procedures from the free-form narrative text.

Hot off the press….

HDM Breaking News, October 5, 2011

Could Stage 2 of Meaningful Use be a Two-Step Process?

An idea floating around Washington could result in Stage 2 of the electronic health records meaningful use program being different in each of its two years.

That's what Dan Rode, vice president of advocacy and policy at the American Health Information Management Association, told an audience during the AHIMA 2011 Convention & Exhibit in Salt Lake City.

Stage 2 starts in October 2012 for hospitals and January 2013 for eligible professionals, just when providers will be struggling to meet the ICD-10 deadline in October 2013.

So the scenario could be that Stage 2 starts in January 2013 with minor changes from Stage 1, such as raising meaningful use quality measures a bit. But any major changes or new requirements, such as requiring the use of SNOMED CT in certain parts of the medical record, would wait until 2014, Rode said.

The Office of the National Coordinator wants to begin building Stage 3 requirements in January 2013 to give providers more time to comply by 2015.

In summary…

Are our sights set on the right goal?

- Are we ‘just’ implementing new software and technology or are we aiming to see successful adoption of the technology into clinical practice in both the hospital and ambulatory settings?
  - Do we have tactical plans behind our strategic plans to backup and ensure we all understand the ultimate goal?
  - Are we measuring our success off the right metric?

Summary

- We will see at least one major disruption per year to business that will require major updates to EHR functionality and workflow
- All of these functions being proposed through various regulatory measures are theoretically desirable and necessary to advance treatment **and** if we move fast enough we have some financial help to offset their costs
- All vendors will be pushed to the max in order to meet this moving target (software, interfaces, installation, training etc.)
- Persons (consumers, patients, families, caregivers and practitioners) must be empowered to expect, person-centered and person-directed outcomes

Summary cont.

- There are still some major players missing from the Meaningful use sandbox
  - Long Term and Post Acute Care (LTPAC) facilities
  - Mental Health facilities
  - Points of Service other than 21 (IP) and 23 (ED) in the hospital setting
  - Substance use treatment facilities
- We must remember the importance of collecting outcome, quality and performance measures as well as evaluation methods of such data and make these part of normal operations and on-going process improvement activities

Why we need to keep working on the sharing of information in a meaningful way…..

The Centers for Medicare and Medicaid services estimate that nearly 18% of Medicare patients are re-hospitalized within 30 days of discharge and that 13% of all admissions costing $12 billion dollars are potentially avoidable

Evidence on the Costs and Benefits of Health Information Technology. Congressional Budget Office

Summary cont.

- Ensure that standards-based interoperability is incorporated into the certification criteria to allow meaningful data exchange across all care settings
- Advocate for the adoption and utilization of standardized health summaries (e.g. CCD) for patient health information exchange between hospitals and Long Term and Post Acute Care) settings
- Educate providers and policymakers about the need for timely electronic information exchange between settings to reduce medication errors, duplication of services, and waste of resources, which may lead to reduction in hospital admissions and readmissions
- Summarize lessons learned and successful strategies for participation in HIEs

Conclusion…

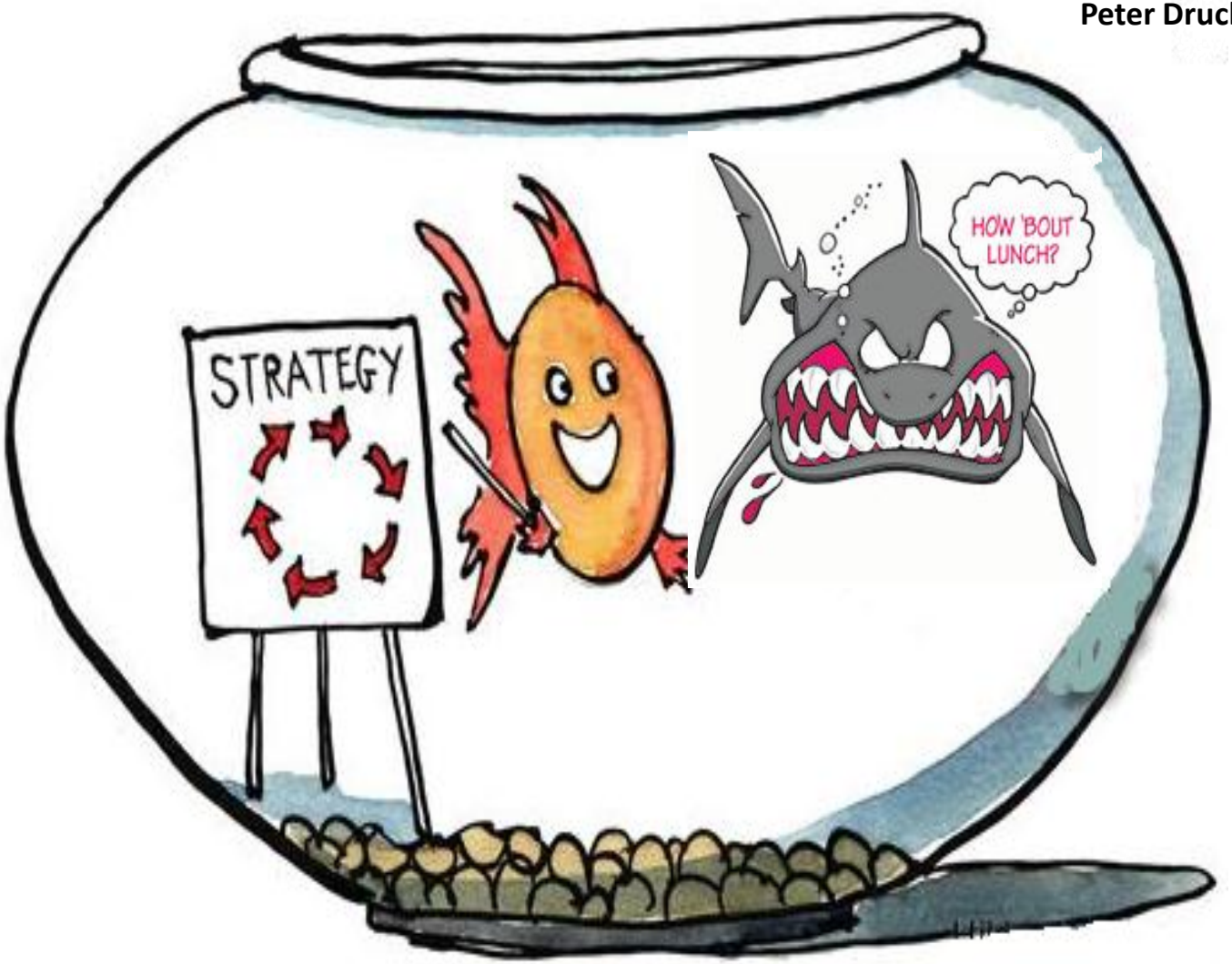
HIEs and interoperable health IT platforms have the potential to transform healthcare, improve quality to our patients, increase efficiencies, and increase cost savings.

Our health 'system is one-dimensional and reactionary today. We must become dynamic and proactive by becoming patient-centered. We need to move into longitudinal electronic health records, focusing on interoperability and sharing of information while improving our security & privacy standards and promoting the adoption of certified EHRs and HIEs.

Questions……

"Culture eats strategy for breakfast"

Peter Drucker



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