

“MEANINGFUL USE”: WHAT DOES IT MEAN?

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Outline



- A little about us
- Health Reform and HIT
- ARRA & HITECH—a quick overview
- What is meaningful use?
- Meaningful use: our take on it
- Discussion

The College of St. Scholastica

- The School of Nursing, The School of Health Sciences & The Center for Healthcare Innovation
 - ATHENS EHR Project
 - Academic Electronic Health Record Subscription Service
 - Personal Health Record Project
 - Rural Hospital EHR Optimization Project
 - Nursing Education, Practice, and Retention Project
 - HIM and Nursing have nationally recognized undergraduate and graduate programs
 - Health Sciences and Nursing are nationally recognized for technologically enhanced learning environment
 - Center for Healthcare Innovation works with colleges and universities around the country to implement EHRs into the classroom
 - College has a long-standing history of serving rural communities
- Faculty involved in:
 - RHIOs, CCHIT, e-Health Advisory Committees, National Rural HIT Coalition

We were meant for this work...



SISTER EHR

Health Care Reform is the REAL Stimulus



- Currently the US system is:
 - ▣ Expensive, we spend more on healthcare than any other nation
 - ▣ Ineffective, many low quality outcomes on standards comparable to other countries
 - ▣ Fraught with high rates of medical errors
 - ▣ Not universally available
 - ▣ Structured in a manner unsupportable with impending workforce shortages

Why the emphasis on HIT?



- HIT and EHRs have the POTENTIAL to:
 - Reduce costs
 - Improve the quality of care by delineating areas for improvement
 - Save lives
 - Improve access
 - Redesign the work of providers to focus on critical activities

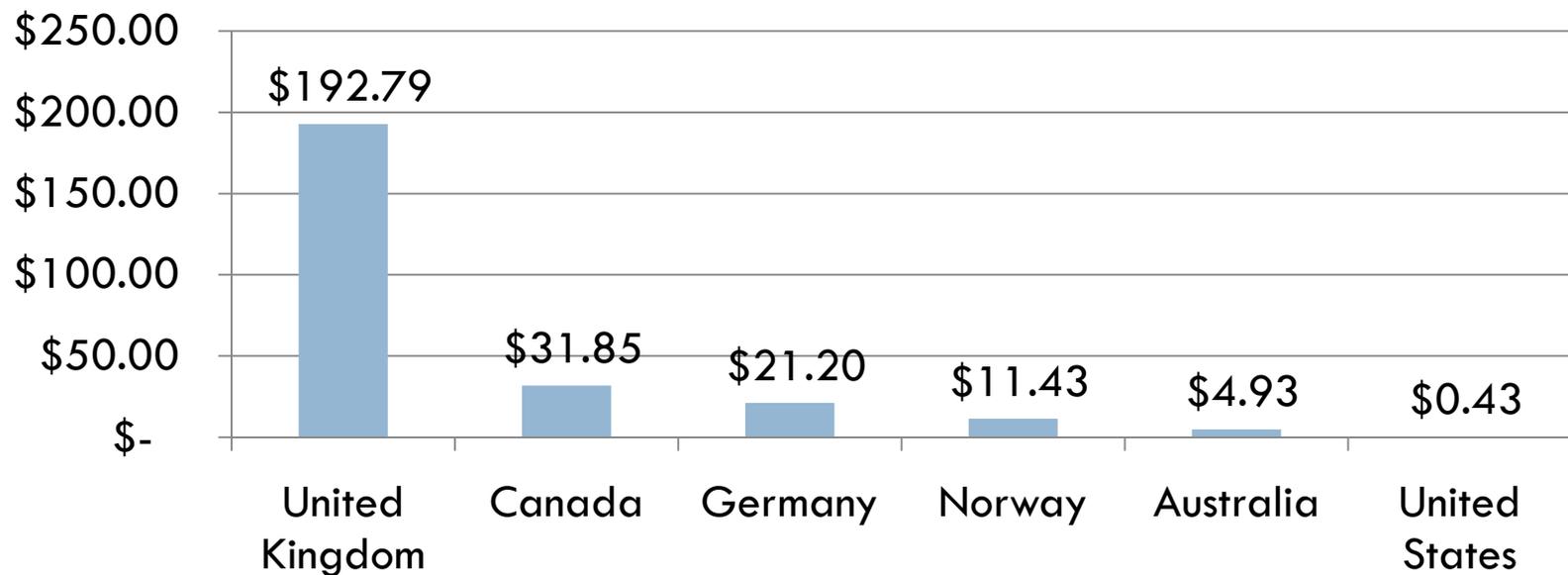
HIT has potential to transform healthcare



- Dr. David Blumenthal, the National Coordinator of Health IT, recently said:
 - *Health IT has the potential to save the federal government more than \$12 billion over 10 years, improve the quality of care, and make our health-care system efficient”*

Underinvestment in HIT

Per Capital Spending on Health Information Technology



Source: Anderson, G. F., Frogner, B. K., Johns, R. A., & Reinhardt, U. E. (2006). Health Care Spending And Use Of Information Technology In OECD Countries. *Health Affairs*, 25(3), 819-831.

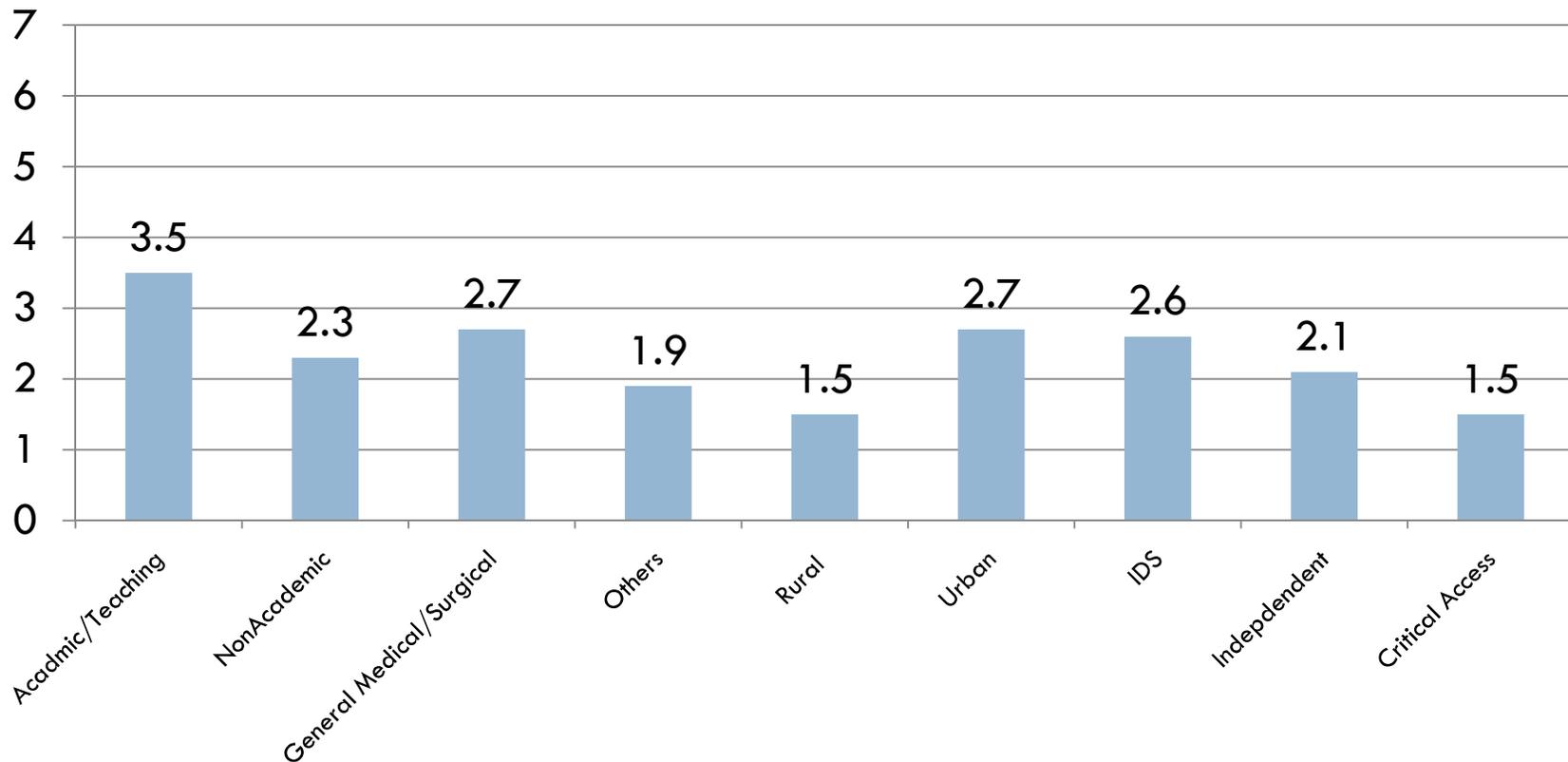
EMR Adoption ModelSM

Stage	Cumulative Capabilities	% of US Hospitals 3rd Quarter
Stage 7	Medical record fully electronic; CDO able to contribute to EHR as byproduct of EMR	0.0%
Stage 6	Physician documentation (structured templates), full CDSS (variance & compliance), full PACS	0.6%
Stage 5	Closed loop medication administration	1.4%
Stage 4	CPOE, CDSS (clinical protocols)	2.2%
Stage 3	Clinical documentation (flow sheets), CDSS (error checking), PACS available outside Radiology	24.1%
Stage 2	Clinical Data Repository, Controlled Medical Vocabulary, Clinical Decision Support System (CDSS) Capability	39.1%
Stage 1	Ancillaries – Lab, Rad, Pharmacy	15.0%
Stage 0	All three Ancillaries not installed	17.6%

Source: HIMSS AnalyticsTM Database (derived from the Dorenfest IHDS+ DatabaseTM).

HIMSS EMR Adoption Model

EMR Scores by Hospital Type, 1st Qtr 2009



Source: HiMSSanalytics. Accessed at www.himssanalytics.org

Barriers to Adoption



1. Cost
2. Lack of Standards (interoperability)
3. Privacy and Confidentiality Concerns
4. Resistance to Change
5. Workforce Issues
6. Complexity of the Change

System Failures

- Implementing these system successfully is a highly complex endeavor. Depending on how one defines “failure,” it is estimated that over 50% of EHR systems fail. [1-2]
- Fewer than 40% of large systems purchased from vendors reportedly meet institutional goals [3]

1. Lorenzi, N. M., Smith, J. B., Conner, S. R., & Champion, T. R. (2004). The Success Factor Profile for clinical computer innovation. *Stud Health Technol Inform*, 107(Pt 2), 1077-1080.
2. Proceeding of the 11th Annual Symposium on Health Information Management Research, 2006
3. Kaplan, B., & Shaw, N. T. (2004). Future directions in evaluation research: people, organizational, and social issues. *Methods Inf Med*, 43(3), 215-231.

American Recovery and Reinvestment Act of 2009

- President Obama signed the Act into law on February 17, 2009
- Includes stimulus funds for HIT through HITECH Act Provisions



ARRA Vision

- "Our recovery plan will invest in electronic health records and new technology that will reduce errors, bring down cost, ensure privacy, and save lives."

~President Obama,
Address to Joint Session
of Congress, February
24, 2009



What we know....

- **The HIT entire arena is highly complex, which is illustrated by the plethora of acronyms!**
- When discussing meaningful use of EHRs, we find that humor helps.
 - **HITECH: An Interoperetta in Three Acts**
<http://www.youtube.com/watch?v=Gv1s8fM3mMk>

American Recovery and Reinvestment Act of 2009

- **HITECH ACT creates:**
 - **HIT Policy Committee**
 - **HIT Standard Committee**
 - **Process for adopting recommendations from these Committees**
 - **ONCHIT (permanent)**
 - **HIT Extension Program**
 - **Research Centers**
 - **Extension Centers**
 - **State Grants**
 - **Medicare/Medicaid Incentives (meaningful use)**

“HITECH” ACT: Health IT Provisions



- “Health Information Technology for Economic and Clinical Health Act”
 - Overall, the Act provides \$31 billion dollars for health information technology infrastructure and Medicare and Medicaid incentives

HITECH Funding

- \$2 billion in direct funding for health IT efforts through the Office of the National Coordinator
 - ▣ \$300 million reserved for supporting regional health information exchange efforts
 - ▣ \$20 million reserved for national Institute on Standards and Technology

- Incentives through Medicare and Medicaid to providers and hospitals that adopt and use health IT systems
 - ▣ Starting in 2011 and increases the deficit by \$29 billion through 2019
 - ▣ Includes Medicare penalties that start in 2015
 - ▣ Health IT expected to reduce federal spending by approximately \$12 billion

ARRA for Professionals

- Medicare Incentive Payments for Professionals
 - ▣ If physicians are using a qualified EHR in 2011 or 2012, they can receive up to \$44,000 through Medicare
 - ▣ Physicians practicing in “health professional shortage areas” can receive a 10% additional payment, for a total of \$48,400
 - ▣ Applies to all physicians who can prove meaningful use of a qualified EHR, regardless of purchase date
- Medicaid Incentive Payments for Professionals
 - ▣ A professional in a FQHC or RHC with at least 30% needy individuals
 - ▣ Other non-hospital based professionals with at least 30% Medicaid patient volumes
 - ▣ Pediatricians with at least 20% Medicaid patient volumes

ARRA & Medicare

- **Medicare Incentive Payments for Hospitals**
 - Hospitals can receive up to \$8 million over four years if they are using health IT starting in 2011
 - Paid only a pro-rated amount of the total based on Medicare share and transition factor
 - Critical Access Hospitals are eligible for incentives that cover actual costs based on Medicare share plus 20%
 - Covers an average of 86% of allowed costs
 - Medicare payments reduced for non-users beginning in 2015

ARRA & Medicaid

- Medicaid Incentive Program
 - New Medicaid payments to certain providers with high Medicaid volumes to cover the providers costs of acquiring, using and maintaining certified EHR technology
 - Payments can cover up to 85% of the providers' costs and are matched at 100% Federal Financial Participation (FFP)
 - Minnesota's costs for administering the payments would be matched at 90% FFP
 - The State would be responsible for covering 10% of the costs of administering the new payments

ARRA & Medicaid



- Medicaid Incentive Payments can be made to:
 - Children's hospitals (regardless of Medicaid patient volume)
 - Acute care hospitals with at least 10% Medicaid patient volume (including CAHs)
 - A professional in a FQHC or RHC with at least 30% needy individuals
 - Other non-hospital based professionals with at least 30% Medicaid patient volume

Meaningful Use



- To receive any of these incentive payments, the “eligible professional” or hospital must be a “meaningful EHR user.”

Defining Meaningful Use

- The National Committee on Vital and Health Statistics held a hearing on “meaningful use” of health information technology on April 28-29, 2009
 - Over 100 stakeholders testified, and, for the most part, agreed that meaningful use should include interoperability, reporting quality measures, and clinical decision support

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Defining Meaningful Use



- Nevertheless, with input from a broad group of stakeholders, the HHS Secretary, Kathleen Sebelius, will define meaningful use. The definition will eventually affect all healthcare providers and institutions in the country.
- There is presently no definition, but we've heard it may be released on June 16th—tomorrow!

Key to Health IT Reform



□ "The definition (of 'meaningful use') will inform everything that we do that is related to health IT."

- David Blumenthal, MD, National Coordinator for Health Information Technology, April 28, 2009

This is What We Know Now



1. Using certified EHR technology in a “meaningful manner,” including electronic prescribing, to the “satisfaction of the Secretary”
2. Demonstrates “electronic exchange of health information to improve the quality of health care, such as promoting care coordination,” to the satisfaction.....
3. Reporting on clinical quality measures to the satisfaction....

Certified EHR Technology

The ARRA defines “qualified electronic health record”
as:

an electronic record of health-related information on a 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.*

*Note: emphasis added

Certified EHR Technology

- Certification Commission for Health Information Technology (CCHIT) is the body that currently certifies EHRs
 - ▣ Ensures privacy and security of patient records
 - ▣ Ensures ability to send information between other healthcare related entities, such as laboratories and pharmacies
- CCHIT is now assigning certification criteria to each of ARRA's EHR qualifications

Information Exchange



- The EHR user must demonstrate that the EHR is used “for the electronic exchange of health information to improve the quality of health care, such as promoting care coordination.”
 - Laboratory
 - Medication
 - Radiology
 - Demographics

Reporting on Measures



- The EHR is used by eligible professional to submit information, “in a form and manner specified by the secretary, on such clinical quality measures and such other measures as selected by the Secretary.”
 - All measures will require public comment before selected
 - “The Secretary may not require the electronic reporting of information under subparagraph (A)(iii) unless the Secretary has the capacity to accept the information electronically.”

Quality Measures



- Stakeholders testified that measures should focus on:
 - Quality deficits
 - High variation
 - Inappropriate utilization
 - High costs
 - Some want to keep the number of measures low—subset of NQF-endorsed measures

Demonstration of Meaningful Use

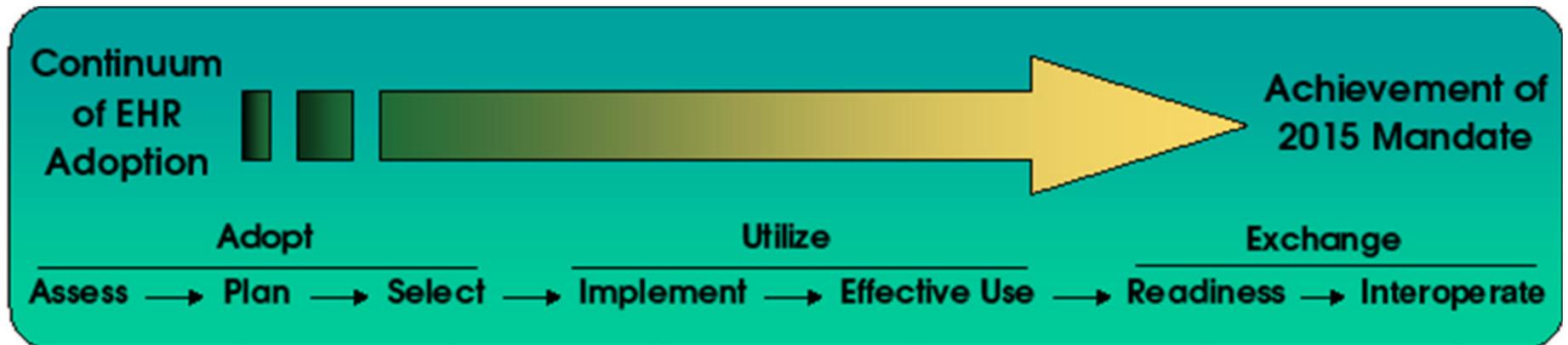
- Professionals and hospitals “may satisfy the demonstration requirement” by:
 1. *An attestation*
 2. *The submission of claims with appropriate coding (such as a code indicating that a patient encounter was documented using certified EHR technology)*
 1. *E-prescribing: using Part D data to*
 3. *A survey response*
 4. *Reporting of measures using EHR—NQF, etc.*
 5. *Other means specified by the Secretary—patients, Leap Frog,*

Meaningful Use: Our Take

- The emphasis has to be on defining meaningful use in a way that emphasizes **USE**, not simply adoption.
 - ▣ without trained IT & HIM staff, organizational champions, a climate that promotes change, and clinician engagement, EHRs will fail to meet objectives, whatever they are.
 - ▣ We are “drowning in data, but starved for knowledge.”
- Meaningful use must be defined **dynamically**, be tied to health reform goals, and accommodate a phased-in approach:
 - ▣ Decision-support
 - ▣ Health information exchange
 - ▣ Quality reporting

Meaningful Use: Our Take

- Effective use (aka meaningful use) should include the entire continuum, as emphasized by the MN e-Health Initiative—from assessing through interoperability



Meaningful Use: Our Take

- **Focus of meaningful use must be patient-centric.**

“IT is a tool, not a goal. Success should not be measured by the number of hospitals with computerized order entry systems or patients with electronic personal health records. Success is when clinical outcomes improve. Success is when everyone can learn which methods and treatments work , and which don’t, in days instead of decades.”

~Carol C. Diamond and Clay Shirky [1]

Questions?

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