

FALL 2009 IDN SUMMIT
PEER-TO-PEER LEARNING EXCHANGE
RESEARCH REPORTS

EHR Selection



Final Report October 2009. Information compiled by Healthcare Business Media, Inc in cooperation with the Exchange facilitators. For any questions or comments please contact Lisa Ponssa, lisa@idnsummit.com or 866.530.4441 ext. 2.

Rough Outline

Our Objectives for Wednesday, September 25th:

- Peer to Peer discussion around key incentives and meeting "meaningful use" criteria around electronic health records
- How is your organization planning to meet "meaningful use" criteria under the HITECH Act?
- How can we improve the certification process from Electronic Health Records
- Ideas on how to expedite moving your organization towards increased EMR adoption?
- What is my organization doing to educate more certified health care information technology professionals to support EHR adoption

The Basics of ARRA Incentives

Medicare Incentives for Hospitals

Medicare Incentives for Physicians

Qualifying for Medicare Incentives

Initial Definitions of Meaningful Use

Revised Definitions of Meaningful Use: July-August 2009

- EHR Selection: Making the Most Appropriate Decisions in the Era of Meaningful Use
 - Start by clearly defining your clinical and business needs for a system
 - Make a scorecard of functional requirements
 - Make a short list of vendors
 - Ask the short list of vendors to share with you at least one troubled installation or organization that no longer uses their solutions***
 - Use an EHR selection consulting firm that has no relationship with the EHR vendors-Most of the major consulting firms have relationships with the major vendors and are not necessarily un-bias in their selection criteria
 - Key goals- How does EHR improve the quality of patient care for patients that have services at your organization? How will this act as a competitive advantage versus the other health care providers in your market?
- Resources
 - o Resources on ARRA
 - o Resources on EHR Selection

2008-2009 EMR Adoption Model Trends			
		2009 Final	2009 Q2
Stage 7	Medical record fully electronic; HCO able to contribute CCD as by-product of EMR; Data warehousing/mining	0.3%	0.3%
Stage 6	Physician documentation (structured templates, full CDSS (variance & compliance), full R-PACS	0.5%	1.0%
Stage 5	Closed loop medication administration	2.5%	4.5%
Stage 4	CPOE, Clinical Decision Support (clinical protocols)	2.5%	3.6%
Stage 3	Clinical documentation (flow sheets), CDSS (error checking), PACS available outside Radiology	35.7%	38.4%
Stage 2	Clinical Data Repository, Controlled Medical Vocabulary, CDSS inter-ence engine, may have Document Imaging	31.5%	31.4%
Stage 1	Ancillaries - Lab, Rad, Pharmacy - All Installed	11.5%	7.2%
Stage 0	All Three Ancillaries Not Installed	15.6%	13.4%

Source: HIMSS Analytics™ Database

N=5,170/5,172

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Introduction to Report

- To assist supply chain executives, this issue brief provides the following:
 - o Background and updates on meaningful use criteria as developed by the HIT Policy and Standards Committees within ONC
 - o EHR selection criteria
 - o Resources

The Basics of ARRA Incentives

Within the American Recovery and Reinvestment Act of 2009 (ARRA), signed into law on February 17, 2009, the Health and Information Technology for Economic and Clinical Health Act (HITECH Act) provides \$19.2 billion to promote the adoption of health information technology (HIT), including the widespread implementation of electronic health records (EHRs) over the next five years.

Medicare and Medicaid plans to offer financial incentives to both eligible professionals and hospitals that can demonstrate meaningful use of certified EHRs. Medicare also plans to impose penalties in the form of reduced reimbursement on those who fail to use qualifying EHR technology on time.

Medicare Incentives to Hospitals

Beginning in October 2010 Medicare will provide incentive payments to general acute care hospitals and critical access hospitals (CAHs) that can demonstrate to the Department of Health and Human Services (HHS) meaningful use of certified EHRs. A hospital that is a meaningful user can receive up to four years of financial incentive payments.

Medicare will determine the amount of incentive payments for each individual hospital using a formula based on the product of (1) a base amount of \$2 million, plus \$200 for every discharge between 1,150 and 23,000, (2) the Medicare share, and (3) a transition factor that phases payment amounts down over the four years.

This means that hospitals can receive greater incentives if they demonstrate meaningful use earlier. However, Medicare won't make any incentive payments to hospitals that become meaningful users after 2015. For hospitals that fail to become meaningful users, beginning in federal fiscal year 2015 (October 2015), Medicare will reduce reimbursement payments. Hospitals that are not meaningful users for a fiscal year will likely receive a net reduction of 25, 50, 75, and 100 percent of the market basket update that would otherwise apply in fiscal years 2015, 2016, 2017 and after.

Medicare Incentives for Physicians

Physicians and other eligible professionals (EPs), who are meaningful users of certified EHRs can receive financial incentives of up to \$44,000 (per provider), paid over a five-year period beginning in calendar year 2011 (January 2011) and ending in 2016. Medicare won't pay incentives to EPs who first become meaningful users in 2015 or later. In addition, for EPs who are late adopters of EHR technology, beginning in 2015, Medicare will impose reimbursement reductions in the Medicare fee schedule amount for professional services for failure to demonstrate meaningful use of certified EHRs as follows:

- One percent decrease in 2015
- Two percent decrease in 2016
- Three percent decrease in 2017
- Three to five percent decrease in 2018 and beyond.

Qualifying for Medicare Incentives - Initial Definitions of Meaningful Use

To qualify for Medicare incentives, hospitals and EPs must show that they are meaningful users of EHR technology that meets HHS certification standards. However, the HITECH Act failed to include certification standards and a detailed definition of meaningful use. Instead, it requires the Centers for Medicare & Medicaid Services (CMS) to publish regulations defining these key terms by the end of 2009—but more likely in spring 2010, according to David Blumenthal, MD, head of the HHS Office of the National Coordinator (ONC).

The HITECH Act codified ONC and created within it two advisory committees: the HIT Policy Committee and the HIT Standards Committee. These Committees are developing standards for meaningful use and EHR. *To help hospitals receive financial incentives and avoid reimbursement penalties, hospitals and EPs must closely monitor the efforts of ONC and the HIT Policy and Standards Committees as they establish certification standards and define meaningful use.*

The HIT Policy Committee, in particular, will play a critical role in recommending standards for meaningful use to assist in the development of CMS regulations by December 31, 2009 and in finalizing these regulations by spring 2010.

On June 16, 2009, the HIT Policy Committee forwarded its initial recommended definition of meaningful use to the ONC. The HIT Policy Committee meaningful use work group announced its vision for meaningful use: "to enable significant and measurable improvements in population health through a transformed health care delivery system." Guided by this vision, it recommended the following five national priorities (using 2008 National Quality Forum priorities) as themes for defining meaningful use:

- (1) Improve quality, safety, efficiency, and reduce health disparities.
- (2) Engage patients and family.
- (3) Improve care coordination.
- (4) Improve population and public health.
- (5) Ensure privacy and security protections.

The workgroup also developed a matrix of objectives and care processes to define what measures will be required for meaningful use. For each of the priorities, the workgroup set multiple care goals. For each care goal, the matrix includes a list of objectives and measures beginning in

2011 and increasing in scope and complexity in 2013 and 2015. For example, *in the year 2011 and under the initial June 16, 2009 guidelines, providers would need to:*

- Use computerized physician order entry (CPOE) for all order types.
- Implement drug-drug, drug-allergy, drug formulary checks.
- Maintain up-to-date problem lists.
- Maintain active medication lists.
- Maintain active medication allergy lists.
- Record primary languages, insurance type, gender, race and ethnicity.
- Record patient vital signs.
- Incorporate lab tests into EHRs.
- Generate patient lists by condition.
- Send reminders to patients.

Measures within the original June 16, 2009 matrix included, for example, reporting the percentage of hypertensive patients with blood pressure under control. Future objectives and measures effective in 2013 and 2015 will be more challenging. For example, 2013 objectives include use of evidence-based order sets and clinical decision support at the point of care.

Revised Definitions of Meaningful Use: July-August 2009

Based on feedback received from multiple stakeholders, the meaningful use workgroup and other workgroups issued additional sets of recommendation in July and August 2009. According to objectives for 2011 and 2013 providers are to “electronically capture in coded format and to report health information and to use that information to track key clinical conditions.”

To achieve the first policy priority, “to improve quality, safety, efficiency and reduce health disparities”, hospitals must do the following: (Requirements are slightly different for eligible professionals.)

- Perform 10 percent of all orders using computerized physician order entry (CPOE).
- Implement drug-drug, drug-allergy and drug-formulary checks.
- Maintain up-to-date problem lists of current and active diagnoses based on ICD-9 or SNOMED.
- Maintain active medication lists.
- Maintain active medication allergy lists.
- Record demographics (preferred language, insurance type, gender, race, ethnicity).
- Record advance directives.
- Record vital signs (height, weight, blood pressure).
- Calculate and display BMI.
- Record smoking status.
- Incorporate lab test results into the EHR as structured data.
- Generate lists of patients by specific condition.
- Report hospital quality measures to CMS.
- Implement one clinical decision rule related to a high priority hospital condition.
- Check insurance electronically when possible.
- Submit claims electronically to public and private payers.

To “engage patients and families” in 2011, hospitals must respond to patients’ requests to provide them with electronic copies of their health information, including lab results, problem lists, medication lists, allergies, discharge summaries and procedures, on request. Hospitals must also provide patients with electronic copies of their discharge instructions and procedures at the time of discharge, upon request, and give them access to patient-specific educational materials.

To “improve care coordination” in 2011, hospitals must demonstrate that they can:

- Exchange key clinical information (discharge summary procedures, problem lists, medication lists, allergies, and test results) among providers of care and patient authorized entities electronically.
- Perform medication reconciliation at relevant encounters and at each transition of care.

To “improve population and public health” in 2011, hospitals must show they can:

- Submit electronic data to immunization registries and actual submission where required and accepted.
- Provide electronic submission of reportable lab results to public health agencies and actual submission where it can be received.
- Provide electronic syndromic surveillance data to public health agencies and actually transition according to law and practice.

To “ensure adequate privacy and security protections for personal health information” in 2011 hospitals must show that they can:

- Comply with the HIPA Privacy and Security Rule.
- Comply with fair data sharing practices set forth in the Nationwide Privacy and Security Framework.

Each of the 2011 objectives goals comes with a series of measures, which providers must report. Among those for 2011 are the following:

- Percentage of diabetics with A1c under control.
- Percentage of eligible surgical patients who received VTE prophylaxis.
- Percentage of lab results incorporated into EHR in coded format.
- Percentage of all patients with access to personal health information electronically.
- Implemented ability to exchange health information with external clinical entities (labs, care summaries and medication lists).
- Percentage of transitions in care for which summary care record is shared up-to-date status for childhood immunizations.
- Percentage of reportable lab results submitted electronically.
- Performance or update of a security risk assessment and security updates.

The 2013 objective for meaningful use is “to guide and support care processes and care coordination.” *Hospitals must report on fulfillment of 2011 quality measures, as well as the following 2013 measures:*

- Percentage of all orders entered by physicians through CPOE.
- Potentially preventable emergency department visits and hospitalizations.
- Patient access and experience reports using National Quality Forum-endorsed HIT-enabled quality measures.
- Percentage of patients with access to secure patient messaging.
- Inappropriate use of imaging (e.g. MRI for acute low back pain).
- Ability to incorporate data uploaded from home monitoring devices.
- Providing summarized or de-identified data.

The 2015 policy priority, to “achieve and improve performance and support care processes and on key health system outcomes, will be met through the following measures, some of which have yet to be specified”:

- Clinical outcome measures
- Efficiency measures
- Safety measures
- Percentage of patients with full access to PHR populated in real time with EHR data.
- Aggregated clinical summaries from multiple sources available to authorized users.
- HIT-enabled population measures
- HIT-enabled surveillance measure
- Provide patients, on request, with a timely accounting of disclosures for treatment, payment, and health care operations, in compliance with applicable law.
- Incorporate and utilize technology to segment sensitive data.

To summarize, meaningful use priorities for 2011 as articulated in July 2009, providers must be prepared to do the following:

- Allow patients to access health records.
- Develop capabilities to exchange health information.
- Implement at least one clinical decision support rule for a specialty or clinical priority.
- Provide patients with electronic copies of discharge instructions and procedures.
- Submit insurance claims electronically.
- Verify insurance eligibility electronically when possible.
- Allow all patients to access PHRs by 2013.
- Participate in a national health data exchange by 2015.
- Use CPOE systems for 10 percent of all orders of any type, which is still under debate.
- Withhold Medicare incentive payments from providers until HIPAA violations are resolved.
- Allow provider to start implementing health IT process in 2012 with application of 2011 criteria and 2013 criteria for the provider’s third adoption year

Also shaping the definition of meaningful use is the HIT Standards Committee, which met on August 20, 2009 to discuss revisions to meaningful use. The Standards Committee’s clinical quality workgroup recommended criteria (http://healthit.hhs.gov/portal/server.pt/gateway/PTARGS_0_10741_880489_0_0_18/2011%20Measure%20Recommendations_Clinical%20Quality%20Workgroup_08202009.pdf) that include the following:

- Body mass index and asthma management documentation by 2011
- Harmonized clinical measures across age groups and settings
- Identification of diagnoses according to the Systemized Nomenclature of Medicine-Clinical Terms, or SNOMED-CT

The Standards Committee said that providers could qualify for federal incentive payments in 2010 by using SNOMED-CT or ICD-9 medical billing codes, in 2013 by using SNOMED-CT or the newer ICD-10 billing codes, and in 2015 by using SNOMED-CT. The Committee also approved 30 performance measures, 23 of which received endorsement from the National Quality Forum. Among them are the percentage of diabetic patients with successful disease management, percentage of electronically transmitted prescriptions and percentage of smokers offered counseling to quit smoking

The Committee's privacy and security workgroup also provided updates (http://healthit.hhs.gov/portal/server.pt/gateway/PTARGS_0_10741_880497_0_0_18/PRIVACY%20AND%20SECURITY%20STANDARDS%20APPLICABLE%20TO%20ARRA%20REQUIREMENTS.pdf) to its earlier recommendations, suggesting that providers do the following:

- Conduct privacy and security risk assessments.
- Consider EHR systems with features for screen-locking, encryption and wireless networks.
- Ensure the security of internal and external data transfers.
- Implement necessary procedures to coordinate with EHRs
- Review EHR audit trails regularly.

Certification Issues

The Health IT Policy Committee has also adopted recommendations calling for EHR certification by multiple entities. To obtain certification, EHRs must meet minimum criteria and achieve meaningful use objectives to receive Medicare and Medicaid incentive payments. The work group recommended the following:

- Permit open-source software.
- Allow qualification for EHR subsidies under Stark Law exceptions which allow organizations to subsidize the cost of EHRs for physicians.
- Make certification last for four years.
- Use multiple groups to perform HHS certification under a single set of criteria.
- Get the National Institute for Standards and Technology to participate in accreditation and certification decisions.
- Ask ONC to define certification criteria.
- Request that ONC create an accreditation process for certification groups.
- Develop alternative certification processes for self-developed software.
- Insist that vendors receive certification from only one group.
- Allow for 10-12 different certification groups with CCHIT performing interim certification for EHR vendors.
- Develop a program of gap certification for vendors that received 2008 CCHIT certification.

At its July 2009 meeting, the HIT Policy Committee also recommended that health data or information exchanges be certified, using the rationale that certified exchanges would help both hospitals and physicians access systems that have already demonstrated meaningful use. Among the Committee's recommendations are the following:

- Align HIE certification criteria with final rules on meaningful use.
- Allow states to set HIE criteria to complement federal standards.
- Permit providers to choose certified HIEs that meet their needs.
- Let providers meet meaningful use requirements through participation in certified HIEs.
- Develop HIE standards without specific demands for technology or architecture.

The Committee also requested that HIE certification criteria address areas that include auditing, content standards, identity authentication, key measure reporting, messaging standards, patient consent issues, and privacy.

Steps for Improved EHR Selection

Outline a process for EHR selection:

- Develop a team featuring representation from key departments and functions.
- Develop questions for vendors.
- Use a scorecard to document vendor responses.

Understand the organization's priorities:

- Analyze the organization's core clinical, operational and financial problems.
- Develop a needs assessment.
- Prioritize organizational needs.
- Connect needs to EHR system features and functionalities.
- Share needs and suggested features and functionalities with vendors.
- Create an RFP.

Take part in product demonstrations.

- Avoid allowing the salesperson to take complete charge of the demo.
- Test patient visit scenarios using the EHR system.
- Work through specific tasks such as documentation, prescribing, etc.
- Visit "live" installations where you can see the EHR system in action.

Involve interdisciplinary team members in the selection process.

- Include staff from various disciplines and departments.
- Address the organization's clinical and business needs.
- Invite staff to take part in demos and even site visits.
- Allow staff to participate in vendor rating, ranking and discussion.

Guidelines for Evaluating EHR Systems

- Use actual patient cases to test the system.
- Evaluate how well the system addresses the treatment of common diagnoses
- Look at the system's ability to manage multiple chronic conditions.
- Develop workflow scenarios.
- Ask questions related to—
 - Patients taking a specific medication
 - Patients with a specific disease
 - Patients with a certain lab result
- Analyze product functionality according to the following criteria:
 - Meaningful use: Does the system meet current and evolving meaningful use criteria?
 - Ease of use: Does the system perform a function easily and intuitively?
 - Workflow: How well does the system fit within the organization's current workflow? How would the system change the workflow? Does the organization have a budget around clinical process reorganization?
 - Availability:
 - Are desired features and functions available now?
 - Are the features included in the standard product offering?
 - Does the product require customization? By whom and at what price?
 - Cost:
 - How does the product price compare to that of other products?
 - Do desired features, functions and modules add to the standard product price? How much?
 - Is additional third party software required? Cost?
 - Is additional hardware needed? Cost?
 - What are the costs of maintenance and support?

Resources Related to ARRA and the HITECH Act

Recovery.gov

<http://www.recovery.gov>

http://healthit.hhs.gov/portal/server.pt?open=512&objID=1233&parentname=CommunityPage&parentid=2&mode=2&in_hi_userid=10741&cached=true or at <http://www.hhs.gov/recovery/>

Certification Commission on Health Information technology

<http://www.cchit.org>

Health Information Technology for

<http://waysandmeans.house.gov/media/pdf/110/hit2.pdf>

Proposed Revisions in Meaningful Use Matrix (July 2009)

http://healthit.hhs.gov/portal/server.pt/gateway/PTARGS_0_10741_878092_0_0_18/Proposed%20Revisions%20to%20Meaningful%20Use_08142009.pdf

Update on HIT Policy Committee and Its Workgroups (Scroll down to entries for August 20, 2009)

<http://healthit.hhs.gov/portal/server.pt?open=512&objID=1271&parentname=CommunityPage&parentid=6&mode=2>

Health IT Policy Committee

<http://healthit.hhs.gov/portal/server.pt?open=512&objID=1269&parentname=CommunityPage&parentid=5&mode=2>
<http://healthit.hhs.gov/portal/server.pt?open=512&objID=1269&parentname=CommunityPage&parentid=5&mode=2>

HIT Standards Committee

<http://healthit.hhs.gov/portal/server.pt?open=512&objID=1271&parentname=CommunityPage&parentid=6&mode=2>

Achieving the Health IT Objectives of the American Recovery and Reinvestment Act

http://www.markle.org/downloadable_assets/20090430_meaningful_use.pdf

Navigating the American Recovery and Reinvestment Act

<http://www.ehealthinitiative.org/stimulus/>

Health Care Reform and Health IT Stimulus: ARRA and HITECH

<http://futureofid10.org/arra/>

HIT ARRA Implementation Plan

http://www.hhs.gov/recovery/reports/plans/onc_hit.pdf

Federal Coordinating Council for Comparative Effectiveness Research

<http://www.hhs.gov/recovery/programs/os/cerbios.html>

<https://www.ecri.org/comparativeeffectiveness/Pages/default.aspx>

Training and Educating the Informatics Workforce

http://www.amia.org/files/shared/Educating_the_Informatics_Workforce_07_06_09.pdf

Summary of CHIME Member Survey on CPOE Adoption

http://www.cio-chime.org/members/warehouse/research/Resources_Tools/Other/Survey/w7_1_2009_3_31_06.pdf?Print=ON

A Historic Opportunity: Wedding Health Information Technology to Care Delivery Innovation and Provider Payment Reform

http://www.americanprogress.org/issues/2009/05/health_it.html

Wasting Millions by Making Illogical Purchases Based Solely on Physician Preference: Not in My Hospital You Don't!

https://www.ecri.org/Forms/Pages/Physician_Preference_Whitepaper.aspx

AHRQ National Resource Center Health Information Technology

<http://healthit.ahrq.gov/portal/server.pt?open=512&objID=650&PageID=0&parentname=ObjMgr&parentid=106&mode=2&dummy=>

Resources Related to EHR Selection

Health IT Tools (Agency for Healthcare Research and Quality)

http://healthit.ahrq.gov/portal/server.pt?open=512&objID=919&parentname=CommunityPage&parentid=1&mode=2&in_hi_userid=3882&cached=true

Health Information Technology Evaluation Toolkit

http://healthit.ahrq.gov/portal/server.pt/gateway/PTARGS_0_1248_875888_0_0_18/09_0083_EF.pdf

EMR Evaluation Tool and User Guide

<http://www.chcf.org/topics/view.cfm?itemID=21520>

A Critical Pathway for Electronic Medical Record Selection

http://www.compete-study.com/documents/A_Critical_Pathway_For_Electronic_Medical_Record_Selection.pdf

EMR Update

<http://www.emrupdate.com>

EHR Selection Tools and Resources

<https://www.metastar.com/web/professional/docs/DOQ-IT/Vendor/Tools/EHRSelection.doc>

American Academy of Family Physicians Center for Health IT

<http://www.centerforhit.org/online/chit/home.html>

Selecting an Electronic Health Records Vendor

<https://www.metastar.com/web/professional/docs/DOQ-IT/Vendor/Tools/EHRSelection.doc>

American College of Physicians Practice Management Center

http://www.acponline.org/running_practice/practice_management/

KLAS

<http://www.klasresearch.com>

Electronic Medical Records: A Buyer's Guide for Small Physician Practices

<http://www.chcf.org/documents/ihealth/ForresterEMRBuyersGuideRevise.pdf>

AC Group EHR Functionality Report

<http://www.acgroup.org/2009pmsehrreports.html>

CTS Guides

<http://www.ctsguides.com/medical-method.asp>

EMR Consultant.com

<http://www.emrconsultant.com>

Herding Cats: The Challenges of EMR Vendor Selection

http://www.providersedge.com/ehdocs/ehr_articles/Herding_Cats-Challenges_of_EMR_Vendor_Selection.pdf

Should CCHIT Influence Your Vendor Selection

<http://www.futurehealthcareus.com/?mc=cchitehr-selection&page=fht-viewarticle>

Certification Commission on Health Information Technology (Products)

<http://www.cchit.org/products>

Electronic Health Record Information and News

<http://ehrdecisions.com/>

EHR Implementation in Ambulatory Care

http://www.himss.org/content/files/Amb_EHR_Implementation081507.pdf

Selecting and Implementing an EHR: Implementing Quality

<http://media1.acc.org/memberevents/mirro-ga-chapter/msh.htm>

American Medical Association—Health Information Technology

<http://www.ama-assn.org/ama/no-index/physician-resources/16195.shtml>

EMR Selector

<https://www.ehrselector.com/ehrselector/EMRToolkit/ASP/Default.asp>

EHR Scope

<http://www.ehrscope.com>

American Academy of Pediatrics EMR Review Site

<http://www.aapcocit.org/emr/index.php>

CONCLUSION

The Fall IDN Summit EHRs Peer-to-Peer Learning Exchange Lunch took place at the Gaylord Texan on Wednesday, September 23rd from 11:30 am - 12:30 pm. The session was facilitated by Reynold Bryan, Managing Principal of Healthcare Margins, Inc..



IDN SUMMIT AND EXPO

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