

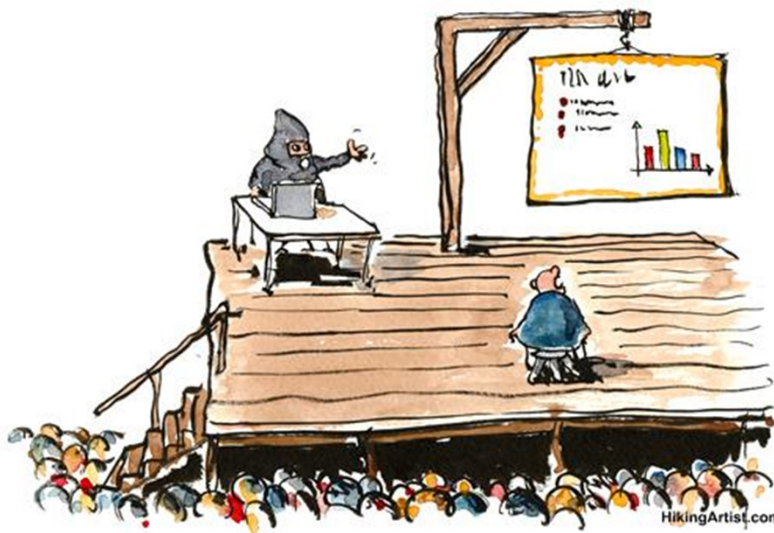


# M-CEITA

*Guiding Michigan Providers  
Through IT Adoption to Meaningful  
Use*

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## Agenda: Death by Powerpoint



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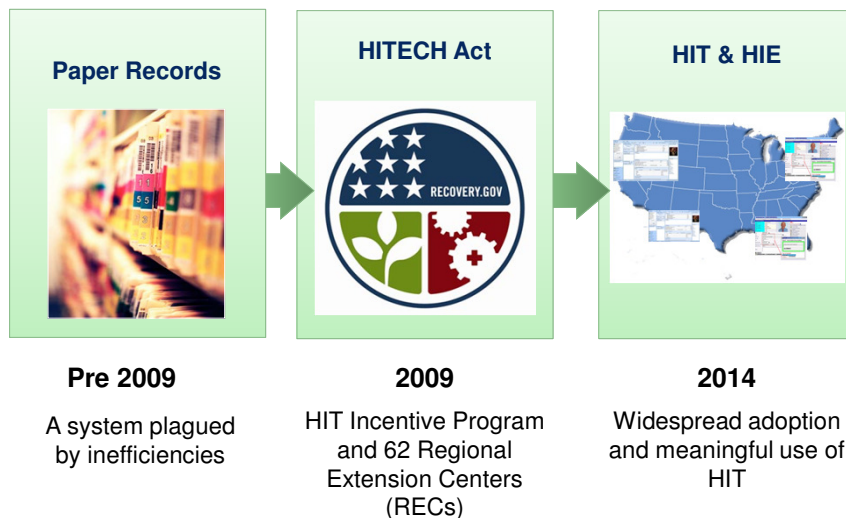


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## Agenda:

- National Overview
- Overview of the Meaningful Use Incentive program
- Some things to think about
- The M-CEITA Program
- The M-CEITA Process

## HITECH Act: Transformation Catalyst Health Information Technology for Economic and Clinical Health (HITECH) Act

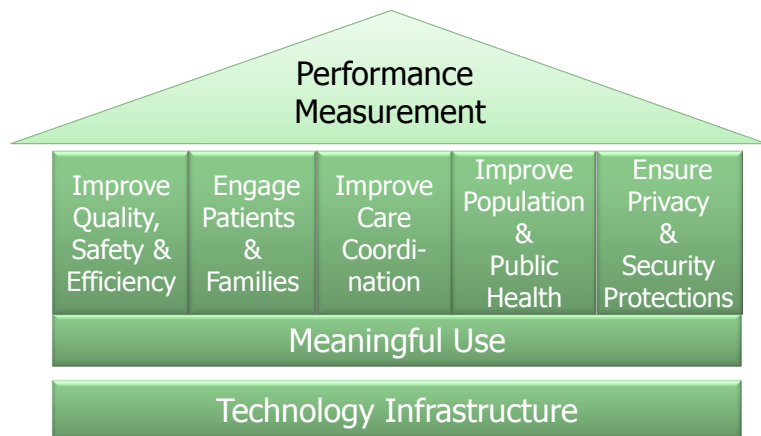




# The Meaningful Use Incentive Program

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## Meaningful Use: Goals & Objectives

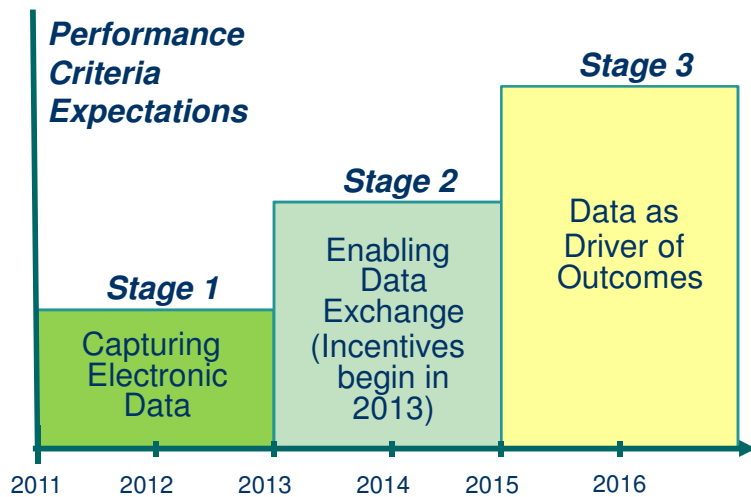


**\*The incentive programs do not focus on the adoption of HIT, but how HIT can be used to further these goals.\***



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## Meaningful Use: Federal Timelines



## To Receive Incentive Payments:

Providers can receive \$63,750 from Medicaid and up to \$44,000 from Medicare if they:

1. Are an eligible provider
2. Use “certified” EHR technology
3. Meet and maintain “meaningful use” criteria

## 1. Who's an Eligible Professional (EP)?

	Medicare FFS or MA	Medicaid
Doctor of Medicine	√	√
Doctor of Osteopathy	√	√
Dentist	√	√
Doctor of Podiatric Medicine	√	
Doctor of Optometry	√	
Chiropractor	√	
Nurse Practitioner		√
Certified Nurse Mid-wife		√
Physicians Assistant (practicing in FQHC or RHC led by physician)		√

- If an Eligible Professional (EP) is eligible for both Medicare and Medicaid, the Eligible Professional may choose to accept the Medicare or Medicaid incentive, but may not receive both.
- An EP is permitted to change their election once during the life of the EHR incentive program, after making the initial election

## 2. Certified EHR Technology

- Certification means that system supports Meaningful Use.
- ONC-Authorized Testing and Certification Bodies (ONC-ATCBs) decide on which tech is "certified EHR technology".
  - Surescripts, LLC; ICSA Labs; SLi GobaL Solutions; InfoGard Laboratories, Inc; CCHIT; and Drummond Group make up the list of certifying bodies.
- <http://onc-chpl.force.com/ehrcert>

### 3. Stage One Meaningful Use Criteria

Eligible Professionals must meet 20 meaningful use criteria and 6 quality measures:

- 15 core criteria
- 5 of the 10 menu criteria
- 6 total Clinical Quality Measures (CQMs)

### Core Measures

Improving quality, safety, efficiency and reducing health disparities	
CPOE for medications (entering into the electronic record)	30%
Drug-drug and drug-allergy interaction checks	YES
E-Prescribing (transmission to pharmacy)	40%
Demographics recorded as structured data	50%
Problem List in ICD-9-CM/ICD-10-CM	80%
Medication List	80%
Medication Allergies	80%
Height, weight and blood pressure recorded as structured data	50%
Smoking status recorded as structured data	50%
At least 1 clinical decision support rule implemented during entire reporting period.	YES
Ambulatory clinical quality measures	YES

## Core Measures cont'd

<b>Engage patients and families in their health care</b>	
Patients requesting an electronic copy of their health information are provided it within 3 business days .	50%
Clinical summaries provided within 3 business days.	50%
<b>Improve Care Coordination</b>	
Electronically exchange key clinical information.	YES
<b>Ensure adequate privacy and security protections for personal health information</b>	
Conduct a security risk analysis and act upon the suggestions.	YES

## Menu Measures

<b>Improve Care Coordination</b>	
Medication reconciliation	50%
Summary of care record for transitions of care / referrals	50%
<b>Improve Population and Public Health</b>	
Test/ Submit electronic data to immunization registries (MCIR)	YES
Test/ Submit electronic syndromic surveillance data to public health agencies (MDCH)	YES

## Menu Measures cont'd

Improving quality, safety, efficiency and reducing health disparities	
Drug-formulary checks enabled	YES
Clinical labs ordered as structured data	40%
Generated at least 1 report listing patients with a specific condition.	YES
Send reminders	20%
Engage patients and families in their health care	
Patients have electronic access to the medical records	10%

## Clinical Quality Measures

- 44 available clinical quality measures, of which you must report on 6:
  - 3 core CQMs
    - Hypertension in Adults (NQF 0013)
    - Preventive Care and Screening (NQF 0028)
    - Adult Weight Screening and Follow up (NQF 0421; PQRI 128)
  - 3 alternate CQMs
    - Weight assessment and counseling for children and adolescents (NQF0024)
    - Preventive Care and Screening: Influenza Immunization for Patients ≥50 Years Old (NQF 004; PQRI 110)
    - Title: Childhood Immunization Status (NQF 0038)

## Payment Guidelines for Public Health

### Medicaid:

- 30% Medicaid volume
- Initial year incentive payment of \$21,250 per EP
- Initial payment year requirements are just AIU = Adopting, Implementing, or Upgrading.
- Register with CMS
- Attest with the state Medicaid agency

## Medicaid Incentive Payments

	CY 2011	CY 2012	CY 2013	CY 2014	CY 2015	CY 2016
CY 2011	\$21,250					
CY 2012	\$8,500	\$21,250				
CY 2013	\$8,500	\$8,500	\$21,250			
CY 2014	\$8,500	\$8,500	\$8,500	\$21,250		
CY 2015	\$8,500	\$8,500	\$8,500	\$8,500	\$21,250	
CY 2016	\$8,500	\$8,500	\$8,500	\$8,500	\$8,500	\$21,250
CY 2017		\$8,500	\$8,500	\$8,500	\$8,500	\$8,500
CY 2018			\$8,500	\$8,500	\$8,500	\$8,500
CY 2019				\$8,500	\$8,500	\$8,500
CY 2020					\$8,500	\$8,500
CY 2021						\$8,500
TOTAL	\$63,750	\$63,750	\$63,750	\$63,750	\$63,750	\$63,750

## Registration

- Opened on Jan 3
- <https://ehrincentives.cms.gov/hitech/login.action>
- What you need:
  - NPI number
  - Nat'l Plan and Provider Enumeration System User ID and Password
  - Payee Tax ID
  - Payee NPI if you're re-assigning your benefits.
  - Enrollment in PECOS (for Medicare only)
  - For Medicaid: note the NLR registration number for attestation
- *You do NOT need certified technology to register.*

## Attestation

- Medicaid for Michigan is open:
  - Once Medicaid receives a valid EP request from the NLR, the Medicaid staff will send a welcome letter to the EP with instructions for logging on to CHAMPS to register for the EHR incentive payment on-line.
  - Once the EP submits the registration information, Medicaid staff will start the review/validation process. In order to ensure that only eligible providers receive EHR incentive payments, a series of verifications will take place at registration, and annually thereafter.

## Delaying attestation doesn't mean delaying the adoption process, though...

- “Even with discounted pricing and more than usual technical support from vendors, the challenges [of HIT Implementation] proved daunting. **Making the tasks more difficult was the need to redefine work processes before implementation rather than after. Technology often floundered on the shoals of practice work redesign.**”\*

And it isn't just workflow redesign – there's a lot of planning involved, too!

\* Nutting PA, Miller WL, Crabtree BF, Jaen CR, Stewart EE, Stange KC. Initial Lessons From the First National Demonstration Project on Practice Transformation to a Patient-Centered Medical Home. *Annals of family medicine*. May 1 2009;7(3):254.

## How does the Incentive Program benefit School and Community Health Clinics?

- When registering with CMS, an Eligible Provider can choose to allocate their incentive payments back to the tax ID of a particular entity, rather than their SSN.
- This becomes a true ROI for the clinic and supplements revenue for the 5 year incentive payout.
- Through attesting on MU criteria, possibility for clinic to increase revenue through increased claims, billing, coding corrections.



## *The M-CEITA Program*

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### **Federal Objective; M-CEITA Mission & Vision**

#### **Federal Government Objective**

- “The regional centers will offer technical assistance, guidance, and information on best practices to support and accelerate health care providers’ efforts to become meaningful users of Electronic Health Records (EHRs).”

#### **M-CEITA’s Mission**

- Partner with Michigan providers to accelerate the selection, adoption and meaningful use of health information technology to improve the quality and efficiency of care delivered in our state.

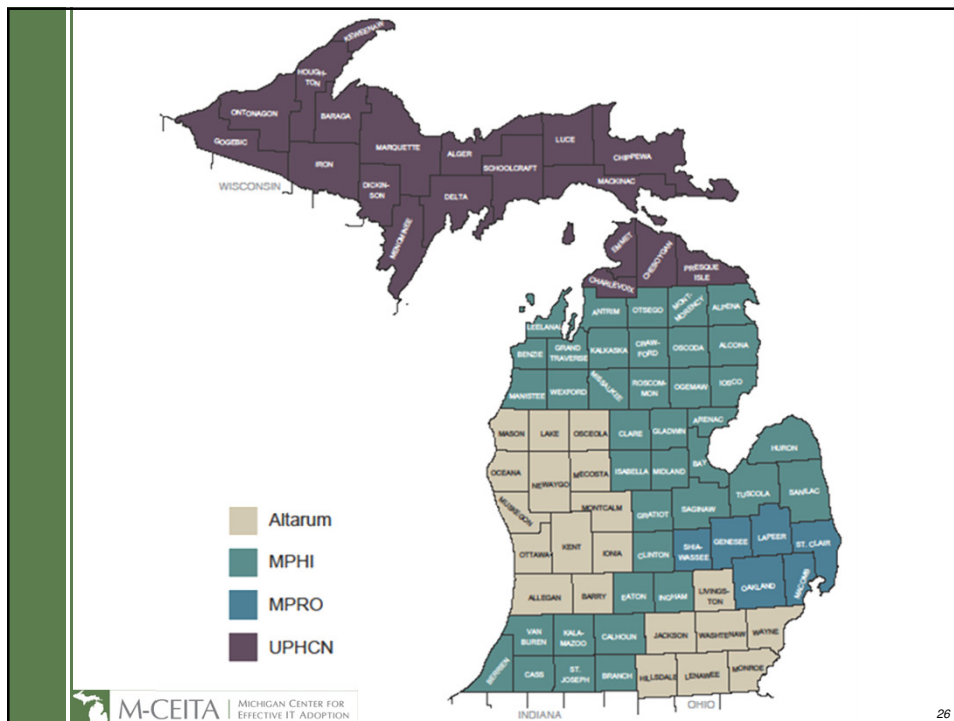
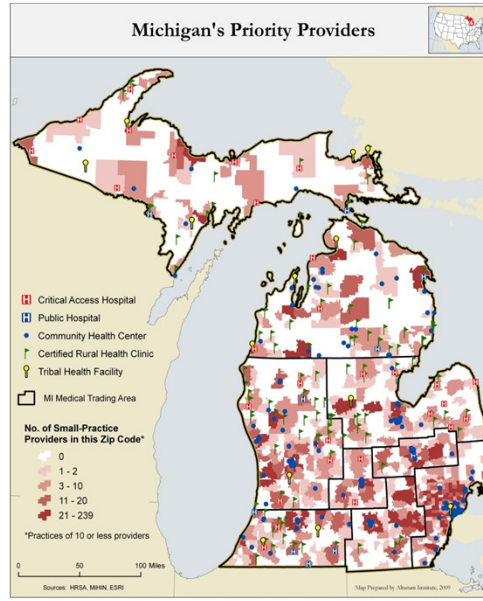
#### **M-CEITA’s Vision**

- As Michigan’s Regional Extension Center, we will serve as a trusted agent on behalf of primary care providers. By 2012, we expect to assist nearly 6,000 of those providers and their patients – imparting broad community benefit throughout the state. Further, M-CEITA will remain a provider resource for years to come through dedication to program sustainability and proven value.

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## Federal Parameters – REC’s Priority Providers

- **Primary Care Providers (PCPs)**
  - MDs, DOs, NPs, CNMs & PAs who practice family, general internal or pediatric medicine or obstetrics and gynecology
- **Priority PCPs**
  - Individual and small group (<10) primary care practices
  - Public and Critical Access Hospitals
  - Community Health Centers and Rural Health Clinics
  - Settings serving uninsured, underinsured, and medically underserved populations
- **M-CEITA Service Area**
  - Goal to reach 4,000-6,000 providers over the first 2 years



## Program Operations

- Individual / Practice / Public Health Departments/  
Community Health Centers/ Physician Organizations /  
Hospitals
- Service Level
  - 50-60 hrs/provider (includes travel time)
- Program Costs
  - ONC estimated costs: \$5,000/provider
  - 90% subsidy through 2014
  - \$500 contract fee/provider (*hardship discount for SCHA-  
MI affiliated providers*)
  - Patient mix & volume discounts
- Federal Funding – milestone payments
- Local Staffing



## *The Process*

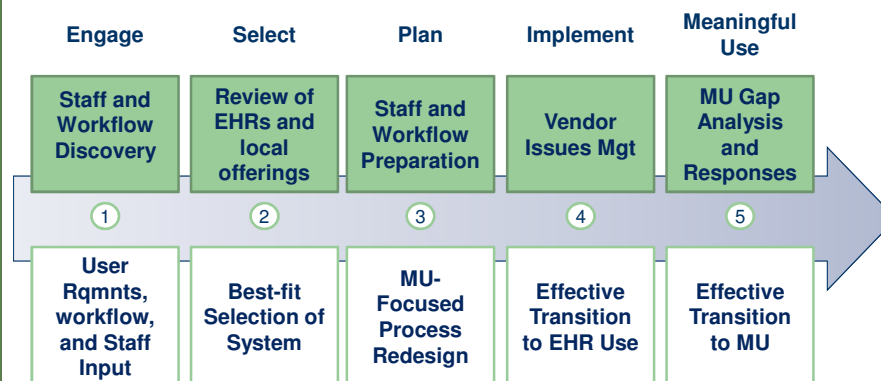
## Across the Entire Adoption Spectrum

- We'll help you choose and implement certified technology in your office...

OR

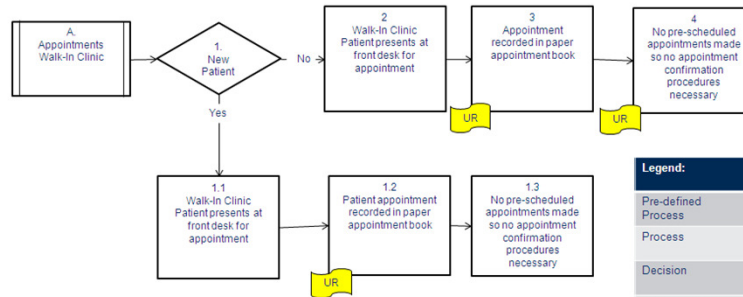
- We'll help eligible providers use their current certified system to meet the criteria for incentive payments Medicaid.

## Comprehensive Support throughout the Entire EHR Implementation Process



## Why is the purpose of each phase?

- **Engagement:**
  - Understand your workflows, current MU-achievement, and requirements for your system
- **Selection:**
  - To find a best-fit system, considering functionality, price, necessary infrastructure, regional offerings, etc.
- **Planning:**
  - To design change strategies and prepare to integrate the EHR system and/or new MU functionality into a practice's workflows
- **Implementation:**
  - To support the practice as changes are deployed to integrate HIT and Meaningful Use
- **Meaningful Use:**
  - To execute strategies to integrate MU functionality into the practice's workflows and ensure MU is achieved.



Legend:	
Pre-defined Process	
Process	
Decision	
On-page reference	
User Requirement	

## Engagement

- **Current State**
  - Assess user readiness, current technology
  - Workflow mapping
  - Interview staff and providers
  - Focus workgroups
  - Meaningful use training
- **User Requirements for the System**
- **Meaningful Use Process Readiness**

## Selection – FUNCTIONALITY FIRST!!

- User Requirements drive selection, also considering:
  - Regional Offerings
  - Vendor Reference Checks

EHR Criteria & Functional Requirements	Priority	Vendor A
<i>Example: The XYZ Functionality and Process</i>		
Description of the functionality and/or work flow	H/M/L	1 2 3
<b>Appointment Scheduling</b>		
Can configure appointment scheduling templates to meet each physician's individual needs and preferences		
Automatically prevent overbooking of appointments		
System allows for manual override of Overbooking but can be limited to specific staff within the office (role-based access)		
Can automatically provide online forms for patient to fill out before visiting office		
Date stamp for confirmation of eligibility information (in the case that it still must take place outside of EHR/PM)	M	
System can make automated reminder calls to scheduled appointments and for recommended preventative visits	H	
System can provide report of all upcoming appointments with contact information, balance info, etc.		
Single-source for eligibility verification/ pre-authorization across all payers that also shows capitated PCP	L	



## Planning

- Implementation plan
  - Goals and timelines for the vendor
  - Hardware purchase and installation plan
  - Transitions between old and new systems
  - "Super-user" training before go-live
  - Document transition
- Impact / Workflow planning
  - Role definitions
  - Meaningful Use required changes
  - 'Future State' workflow
- System integration
  - Interface support
  - HIE integration

### Planning Phase: MU Pre-Assessment and Vendor Crosswalk

Core Set of Objectives and Measures for EPs				Product Name:	Role Responsible for Collecting data at this Practice	Status	Current Threshold
Pillar	Guidebook Measure	MU Objective	MU Measure	Data Field Crosswalk	Practice	Status	Current Threshold
Improving health of populations	Core 1	Use CPOE for medication orders	CPOE is used for more than 30 percent of unique patients				
	Core 2	Implement drug-drug and drug-allergy interactions checks	The EP has enabled this functionality				
	Core 3	Maintain an up-to-date problem list of current and active diagnoses	More than 80 percent of all unique patients seen by the EP have at least one entry or an indication that no problems are known for the patient recorded as structured data				
	Core 4	Generate and transmit permissible prescriptions electronically (eRx)	More than 40 percent of all permissible prescriptions written by the EP are transmitted electronically using certified EHR technology				



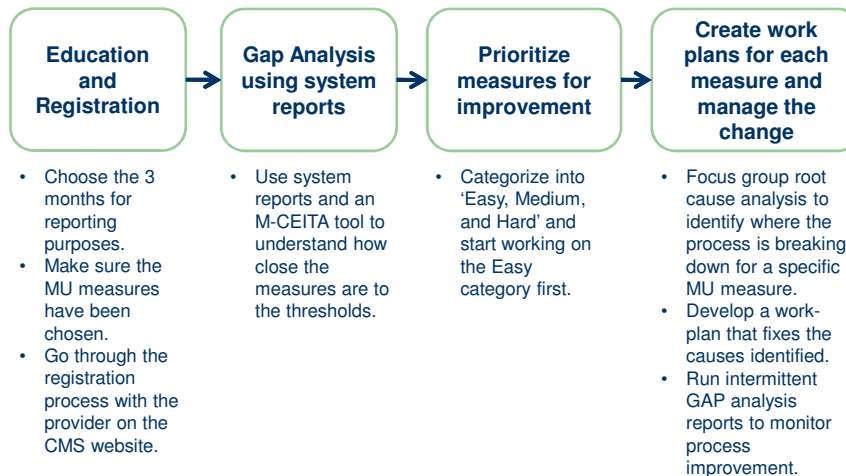
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## Implementation

- Installation, System Testing, and User Testing
  - Compliment vendor services
  - Liaison between vendor and client to ensure deliverables are met
  - System implementation support
  - Troubleshooting and refinement
- Data Management
  - Historical ETL (moving info from historical system to certified system)
  - Documentation planning



## Meaningful Use



## Questions?? Comments??

## Contact Information

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