MEANINGFUL USE: Lessons from the front

RESEARCH BY LEE ANN JAROUSSE

The push is on. There's less than a year to go for organizations to attest for Stage 1 meaningful use to receive the full set of incentive payments, but exactly how many will make it remains to be seen. According to a recent Healthcare Information and Management Systems Society survey, 41 percent of hospitals claimed to be well-positioned to meet Stage 1 requirements; however, 53 percent reported that they are not ready and 6 percent of organizations did not respond.

Thus far, the program has failed to meet expectations, at least in terms of the number of providers applying for incentive dollars and payments being made. The Obama administration orignally estimated it would pay out up to $2.8 billion during fiscal 2011, which ended Sept. 30. Between May *(continued inside)*

MEANINGFUL USE

[continued from cover] and December, 604 hospitals — including critical access hospitals — had received a Medicare incentive payment, totaling $1.109 billion. For all of 2011, Medicaid paid 1,043 hospitals $853 million. The first Medicare incentive payments were made in May; Medicaid started making payments in January 2011.

There are important lessons to be learned from organizations that have attested for meaningful use. "Stage 1 set a pretty high bar," says Chantal Worzala, director of policy at the American Hospital Association. "There's still a lot of work to be done to get all hospitals over the bar." Some of the challenges organizations face in meeting Stage 1 requirements are endemic to electronic health records adoption, while others are related to the actual regulatory requirements. The implementation and upgrading of EHRs is complex and time-consuming and many organizations are struggling with the compressed time frame set by the regulations. The workflow changes alone require significant education and training for clinicians.

Access to capital and workforce issues also are preventing some organizations from progressing. "It's a challenge for organizations to get the folks they need for meaningful use," says Worzala. Clinical informaticists, for example, are in high demand, and many are being hired away by consultants, vendors and other hospitals.

Vendor readiness is another issue. "We still have a supply-and-demand problem with vendors," says Worzala, noting that vendors are struggling to build meaningful use requirements into their products, as well as meeting all of the requests from hospitals and health systems.

The clinical quality measures have proved challenging for some organizations. The data requirements far exceed what most hospitals are currently collecting and many of the data elements still are being captured in written or dictated notes. Worzala notes that some of the clinical quality measures require sophisticated clinical judgment, such as when a stroke patient was last known to be well. Such elements are not easily captured in structured format, Worzala notes.

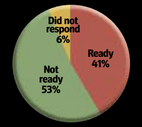
And it's not as if meaningful use is the only priority for hospitals and health systems. ICD-10 and health reform initiatives require significant investment and changes to information systems and processes.

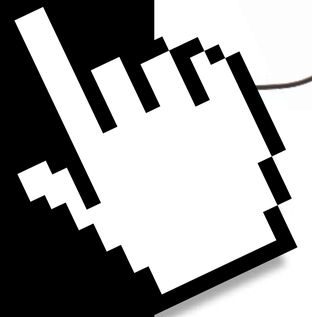
It's important for organizations to approach meaningful use as a quality initiative, as opposed to an IT initiative, says Bob Schwyn, associate principal at Aspen Advisors LLC. "Meaningful use is ... about transitioning data to quality of care," he says, adding, "Meaningful use is a journey, not a destination. The challenge is building a systematic approach to create an environment where data used for quality initiatives is available electronically." ●

The Obama administration originally estimated it would pay out up to $2.8 billion during fiscal 2011. For all of 2011, Medicaid had only paid **$853 million** to 1,043 hospitals.

READY OR NOT?

According to a recent Healthcare Information and Management Systems Society survey, 41 percent of hospitals claimed to be well-positioned to meet Stage 1 requirements.





STAGE 1 CRITICAL SUCCESS FACTORS

Stage 1 establishes a technical platform to build a foundation for the meaningful use of electronic health records, with 2012 being the last year for organizations to attest for Stage 1 and still receive the full incentive payment. Below is a list of critical success factors in achieving Stage 1 meaningful use.

CRITICAL SUCCESS FACTORS	COMPONENTS
Secure organizational support and leadership	• Alignment with organization's strategic objectives • Strategic plan to achieve meaningful use within the organization
Include meaningful use project governance structure	• Define meaningful use project governance structure with appropriate internal reporting • Define budget and allocated resources
Execute meaningful use program /project management	• Establish a project management structure that supports Stage 1 and planning for future stages • Allocate experienced resources to ensure coordination with other technology and implementation • Assign subject matter expert representing all applications, legal and regulatory and training
Implement certified EHR	• A vendor solution that meets organization's EHR objectives • Incorporated access to clinical data that's relevant to providers — give them reason to use EHR beyond demonstrating meaningful use • An EHR privacy and security framework to manage, access, support audit logging, and maintain security of personal health information
Promote EHR system meaningful users	• EHR clinical adoption strategy • Clinical content development including clinical decision support • Comprehensive end-user training with a focus on meaningful use requirements, system use and clinical vocabulary standards • Process and workflow redesign to support system adoption
Define quality metrics	• Ensure that all core and required menu-set quality metrics are met • Measure improved clinical outcomes
Develop a community interoperability strategy	• Ensure health information exchange

Source: Provider HITECH Roadmap, Deloitte, 2010

H&HN HOSPITALS & HEALTH NETWORKS

HOW WE DID IT:
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PROPOSED MEANINGFUL USE OBJECTIVES AND MEASURES FOR STAGE 2

The Centers for Medicare & Medicaid Services have delayed the start of meaningful use Stage 2 until 2014. Below are proposed meaningful use Stage 2 objectives by the Health IT Policy Committee. CMS is expected to implement a final rule for Stage 2 in mid-2012.

REQUIREMENT	HEALTH IT POLICY COMMITTEE'S RECOMMENDATIONS FOR STAGE 2
CPOE for medication orders	More than 60 percent of unique admitted patients with at least one medication or one lab or radiology order in their medication list have at least one medication ordered using computerized provider order entry.
Drug-drug/drug-allergy interaction	Employ drug-drug interaction checking and drug-allergy checking on appropriate evidence-based interactions.
E-prescribing	50 percent of outpatient medication orders and 10 percent of hospital discharge medication orders transmitted as e-Rx.
Record demographics	80 percent of patients have demographics recorded and can use them to produce stratified quality reports.
Report CQM	Report clinical quality measures electronically to CMS.
Maintain problem list	Maintain an up-to-date problem list for 80 percent of all unique patients.
Maintain active medication list	80 percent of medication lists are up-to-date.
Maintain active medication allergy list	80 percent of active-allergy lists are up-to-date.
Record and chart vital signs	80 percent of patients 3 years and older have vital signs recorded during the reporting year.
Record smoking status	80 percent of patients 13 years and older have smoking status recorded.
Implement one clinical decision support rule	Use clinical decision support; Health Information Technology Standards Committee suggests changing certification criteria definition as indicated on comment summary.
Record advanced directive	Make core requirement.* fifty percent of patients 65 years and older have recorded whether an advanced directive exists and access to a copy of the directive itself if it exists.
Implement drug formulary checks	Make core requirement. Implement drug formulary checks according to local needs.
Incorporate lab results	Make core requirement. Incorporate lab results as structured data for more than 40 percent of all lab results ordered.
Generate at least one report listing patients by specific conditions	Make core requirement. Generate patient lists for multiple patient-specific parameters.
Provide electronic copy of health information to at least 50 percent of all patients upon request	This objective is now combined with other objectives.
Provide electronic copy of discharge instructions to at least 50 percent of all discharged patients upon request	This objective is now combined with other objectives.
Identify educational resources	Make core requirement. 10 percent of patients are provided with EHR-enabled patient-specific educational resources.
Provide medication reconciliation	Make core requirement. Medication reconciliation is performed for more than 50 percent of care transactions by receiving provider.
Provide summary of care record	Summary of care record is provided for more than 50 percent of transitions of care and referrals.
Submit immunization data	Make core requirement. Submit immunization data in accordance with applicable law and practice.
Submit lab data to public health agencies	Make core requirement. Submit electronic lab results in accordance with applicable law and practice.
Submit surveillance data	Submit surveillance data to public health agencies in accordance with applicable law and practice.
Conduct a security risk analysis	Perform, or update, a security risk analysis and address deficiencies.
NEW: Electronic medication administration record	Medication orders are automatically tracked via electronic medication administration record (five rights recorded without manual transcription).
NEW: Electronic notes	30 percent of patient days have at least one electronic note by a physician, nurse practitioner or physician assistant.
NEW: Information on hospital admissions	10 percent of patients/families view and have the ability to download information about a hospital admission.
NEW: Labs sent to outpatient providers	Hospital labs send structured electronic clinical lab results to outpatient providers for 40 percent of the electronic orders received.

Source: HIT Policy Committee, June 2011

EXPERT ADVICE

MIKE MISTRETTA | Vice president, information systems, and CIO, MedCentral Health System, Mansfield, Ohio

What are some of the biggest challenges your organization faced in attesting for Stage 1 meaningful use? Of the 14 core measures, which proved the most challenging to meet?
Our biggest challenge to meet Stage 1 was implementing the associated workflows to the clinical processes to capture the requisite data. Some areas were pretty straightforward, such as adding a field to our nursing assessment. Others were more challenging, requiring us to get a department up and running on portions of the system they previously weren't using. Some organizations may have challenges integrating the various applications in their environment. We've had a single-vendor strategy in place for some time and did not have that issue.

For the quality measures, we already had in place a fairly automated process to capture the information, so we were fortunate. Of those submitted, the emergency department measures were the most difficult because of the sheer volume of patients to abstract.

Other than the financial incentives, what benefits has your organization achieved under meaningful use? How has it changed clinical quality?
While we were not bad before, I think we have an increased focus on metrics for our projects and workflow changes. Stage 1 meaningful use in itself really hasn't done much to improve quality, but it sets us on a path to improve over the long haul. By getting more proficient at capturing metrics, we gain a better appreciation of the process changes needed to influence care and, ultimately, outcomes.

What links are your organization finding between meaningful use and health reform?
If one reads the tea leaves ... , it is pretty clear that the electronic exchange of information is going to be a cornerstone. Meaningful use has these capabilities woven throughout, not to mention the only way to effectively manage many of the pay-for-performance measures is to have a comprehensive data set from all care providers, meaning a health information exchange capability must be in place.

PAM McNUTT | Senior vice president and CIO, Methodist Health System, Dallas

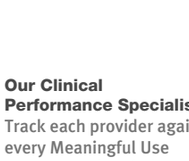
What are some of the biggest challenges your organization faced in attesting for Stage 1 meaningful use? Of the 14 core measures, which proved the most challenging to meet?
I think the CPOE 30 percent watermark remains a barrier to entry for many organizations. But, even for sophisticated organizations, the biggest challenge in meeting meaningful use is reporting the quality measures. The Centers for Medicare & Medicaid Services did recently comment that the quality metrics may not be completely accurate because of changing specifications and data that may not be collected yet in one's system. Also, the measures to provide an electronic copy of a patient's record and discharge instructions sound easy on the surface, but can be quite tricky to track and produce in the formats and time frames required.

What advice do you have for other organizations?
I recommend that organizations meticulously document their reports and back up materials demonstrating compliance with meaningful use and the quality metrics. I have created large notebooks that contain my vendor's reports and screen shots, in some cases to prove we accomplished the measures. You should be prepared to undergo an audit perhaps two or three years out, long after data may have [been] purged from your transactional system.

This is how our cloud-based services help providers get paid for Meaningful Use. Guaranteed.*

5-stage Patient Workflow
Clinical quality measures are embedded into the patient workflow so they can be satisfied with minimal effort. They are collected outside the exam wherever possible and automatic prompts remind providers of the ones that require their attention.

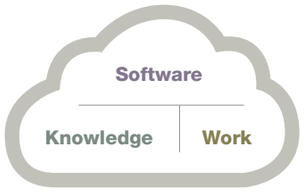
Single Instance
Cloud-based software is continuously updated for the providers on our network as rules change and new Pay-for-Performance programs are introduced. So providers are always on top of change.

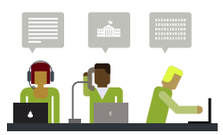


Our Clinical Performance Specialists
Track each provider against every Meaningful Use measure and optimize workflow to the benefit of all providers on the network.

Government
Introduces mandate and requirements.

Our Clinical Intelligence Team
Builds all 44 clinical quality measures into your workflow via our Quality Management Engine.





Our Back-Office Services Team
Takes on the onerous work of registration and attestation to make it faster and easier to secure incentive payments.

Our Account Managers
Provide free coaching and share best practices from across the network to get your providers to the finish line.

Turn the page to read how one of our clients received Meaningful Use payments for 100% of their eligible providers.

athenahealth's **cloud-based practice management, EHR, and care coordination services** offer a proven model for securing Meaningful Use and other pay-for-performance incentives for physicians in your network. In 2011, an **industry-leading 81% of our eligible providers received their Medicare incentive payments.**

Find out how. Visit athenahealth.com/HHN to download our whitepaper *How to Get Paid for Meaningful Use: Tips from the EHR Trenches* or call 888.805.0082 to learn more about athenahealth.

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*If you don't receive the Federal Stimulus reimbursement dollars for the first year you qualify, we will credit you 100% of your EHR service fees for up to six months until you do. This offer applies to HITECH Act Medicare reimbursement payments only. Additional terms, conditions, and limitations apply.

This is how Carolina Health Specialists mastered Meaningful Use.

With 79 providers and nine specialties, Strand Physician Specialists, P.A., DBA Carolina Health Specialists®, needed an electronic health records solution to keep up with the changing health care landscape. And with up to $44,000 of Medicare incentive money on the line per provider, achieving Meaningful Use became an important consideration.

"The pain point generally was the economic realities of modern health care," explains Carolina Health CEO, Ken DeHart, MD. "We pride ourselves on being innovative and we felt it imperative to proactively step forward and adopt an EHR."

After a nearly three-year review, Carolina Health selected athenahealth and their #1 Best in KLAS cloud-based EHR service, athenaClinicals®. The positive results are unmistakable: All 18 of Carolina Health's eligible physicians have attested and received A perfect score.

Carolina Health credits athenahealth's innovative combination of software, knowledge and back-office services. That includes measures built directly into the clinical workflow, free performance coaching and even attestation on behalf of the practice. Carolina Health had more than just a vendor—they had a service partner guaranteeing their success.

"We had so much support from athenahealth that with proper planning and confident monitoring, we did an excellent job meeting our goals," says Business Services director Kari Vereen.

"I talk to physicians that I know adopted an EMR, and ask how they're doing with Meaningful Use," says CFO Debi Randolph. "Their comments are 'I'm not exactly sure where we are on that.' I try not to rub it in to them too much!"

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