California Medical Association

Physicians dedicated to the health of Californians

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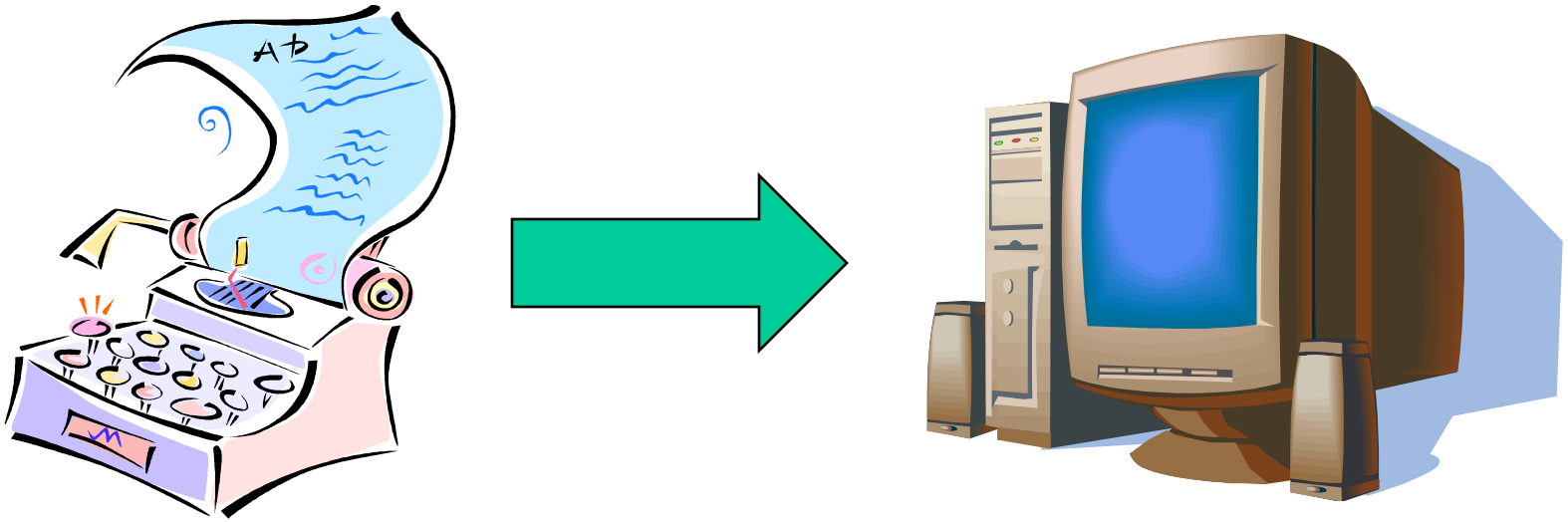
Medical and Regulatory Policy

Think Back a Bit……



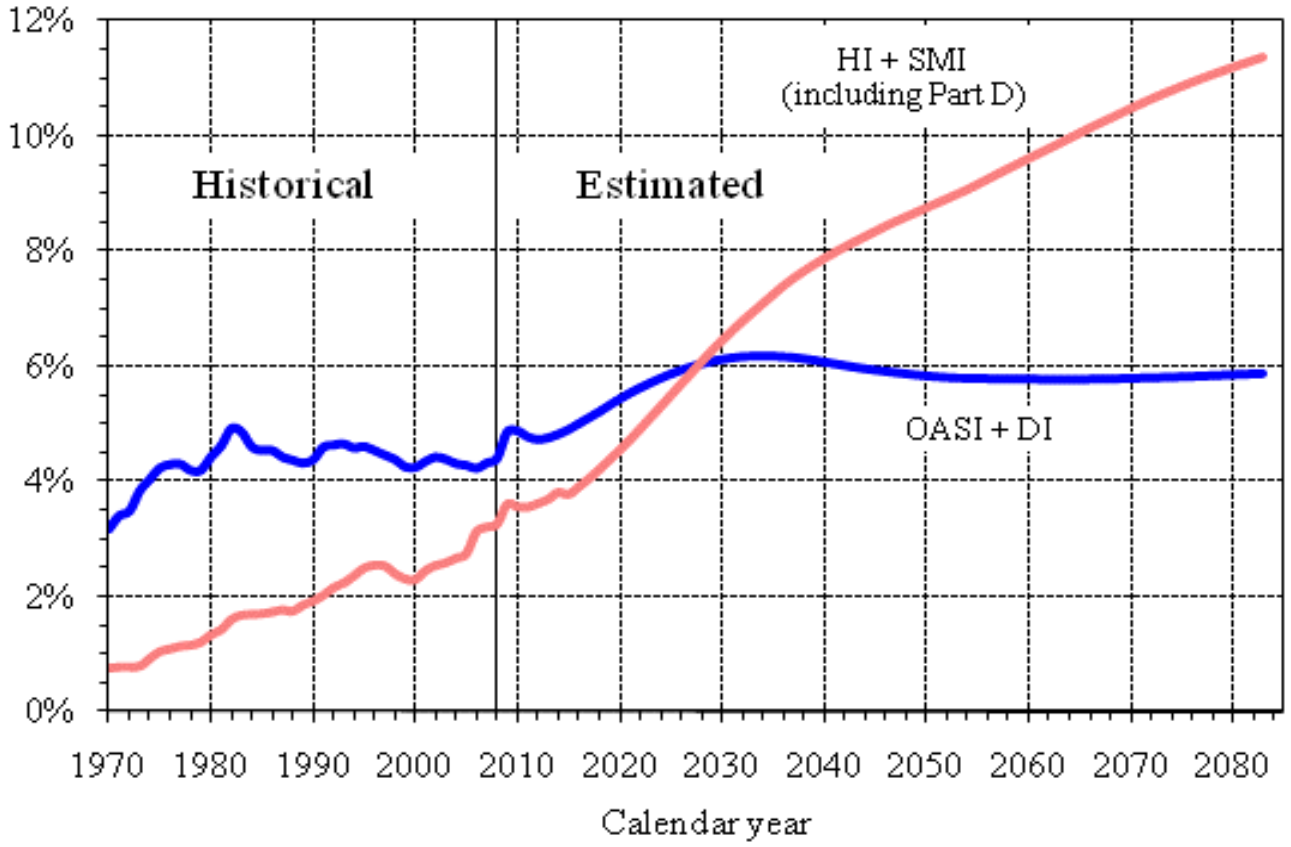
What if we had all just stopped there?

Making the Switch

- Unfortunately, many physician practices that make the switch to EHR use their system as a digital version of a paper record.
- Capabilities such as drug interaction alerts, electronic prescribing, and patient portals are either not present, not enabled, or not acknowledged.
- Two sides of the problem:
  1. High provider dissatisfaction with EHR systems.
  2. Prevents EHRs from being used to drive clinical quality improvement.

The Other Side

Chart B—Social Security and Medicare Cost as % of GDP



The Promise of EHR Adoption

- Provider adoption of EHRs is not an end in itself; it is the groundwork for comprehensive health reform.
- New models of care delivery, such as accountable care organizations and patient-centered medical homes, only work with robust EHRs in physician practices.
- EHRs (when combined with health information exchanges) allow clinical information to be at the point of service in real time.

The American Recovery and Reinvestment Act (ARRA)

The American Recovery and Reinvestment Act (ARRA)

The goal of the provider EHR incentives was not encourage physicians to **adopt** EHR. The goal was to encourage physicians to **USE** EHR.

Financial Incentives

First Year of Adoption

Incentive by Year

	2011	2012	2013	2014
2011	$18,000	--	--	--
2012	$12,000	$18,000	--	--
2013	$8,000	$12,000	$15,000	--
2014	$4,000	$8,000	$12,000	$12,000
2015	$2,000	$4,000	$8,000	$8,000
2016	$0	$2,000	$4,000	$4,000
Total	**$44,000**	**$44,000**	**$39,000**	**$24,000**

What is “Meaningful Use?”

Three criteria listed in the bill:

1. Demonstrate to HHS that EHR was used in a meaningful manner, including e-prescribing.
2. The EHR is connected in a way to facilitate information exchange.
3. The physician reports on clinical quality measures.

Meaningful Use – Two Tracks

Medicare

CMS Regs

Medicaid

DHCS

Final Rule on Meaningful Use

- **Released on July 13th, will be officially noticed in the Federal Register on July 28th.**
- **Per Federal Rules, it takes effect 60 days after it is noticed (September 26th).**
- **Only finalizes meaningful use for the Medicare Incentive Program.**

Three Stages of Implementation

First Payment Year	2011	2012	2013	2014	2015+
2011	Stage 1				
2012	Stage 1	Stage 1			
2013	Stage 2	Stage 1	Stage 1		
2014	Stage 2	Stage 2	Stage 1	Stage 1	
2015+	TBD	TBD	TBD	TBD	TBD

Objectives and Measures

Eligible Providers

- Physician (MD or DO), Dentist, Podiatrist, Optometrist or chiropractor.
- Report on 15 required objectives, plus 5 “menu” items (from a list of 10).
- Each objective has an associated “measure,” which is the criteria the provider will have to demonstrate.

Objectives and Measures

Eligible Hospitals

- Subsection (d) hospitals that either receive FFS Medicare payments or are affiliated with a Medicare Advantage Organization.
- Includes Critical Access Hospitals (approx 60 in California).
- Hospitals will report on 14 required Objectives – they will not report on electronic prescribing, plus five "menu items."

Objectives

- Record patient demographics
- Record vital signs and chart changes (height, weight, blood pressure, body-mass index, growth charts for children).
- Maintain up-to-date problem list of current and active diagnoses.
- Maintain active medication list.
- Maintain active medication allergy list.

Objectives

•Record smoking status for patients 13 years of age or older.

• Provide patients with clinical summaries for each office visit.

• On request, provide patients with an electronic copy of their health information.

• Generate and transmit permissible prescriptions electronically.

• Computer provider order entry (CPOE) for medication orders.

Objectives

- Implement drug-drug and drug-allergy interaction checks.
- Implement capability to electronically exchange key clinical information among providers and patient-authorized entities.
- Implement one clinical decision support rule and ability to track compliance with the rule.
- Implement systems to protect privacy and security of patient data in the EHR.
- Report clinical quality measures to CMS or states.

Clinical Quality Measure Reporting

- Eligible providers will report on six quality measures – three required “core” measures, and three selected from a list of 41.
- Hospitals will report on 15 required clinical quality measures (there are no optional measures for hospitals).
- The measures are selected from NQF or PQRI (providers) or the Joint Commission (hospitals).

Physicians and Other Providers

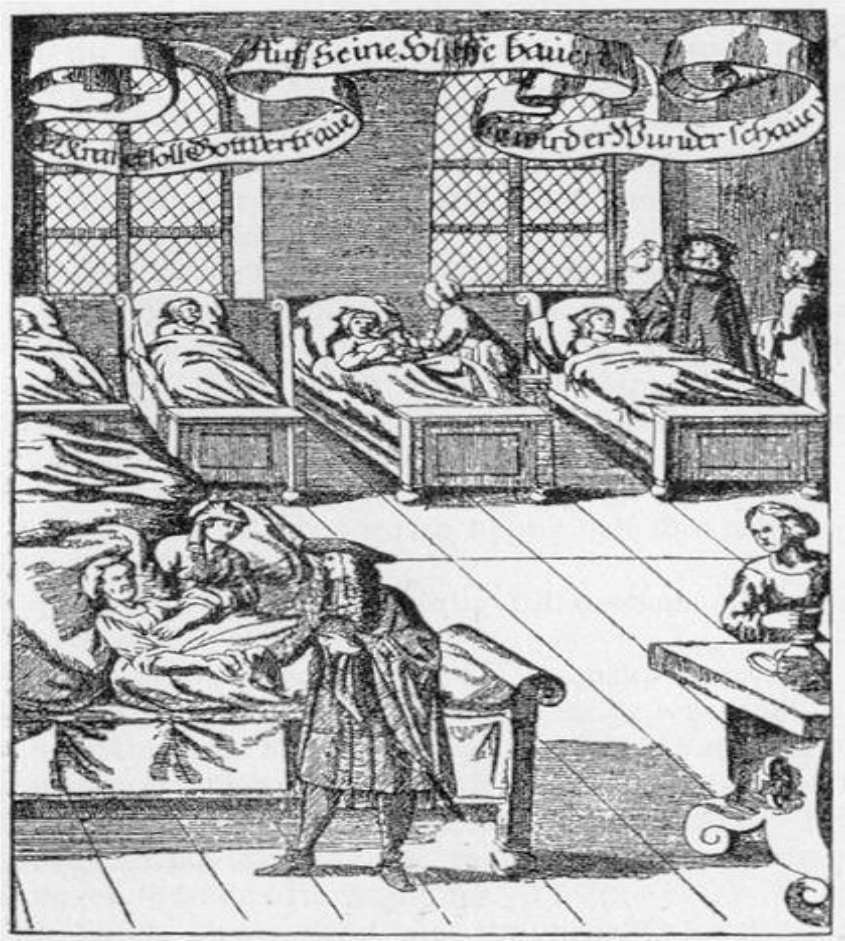
Core Measures: Providers

Core Measures
Preventive Care and Screening Measure Pair: a. Tobacco Use Assessment, b. Tobacco Cessation Intervention.
Hypertension: Blood Pressure Measurement.
Adult Weight Screening and Follow-Up.

Alternate Core Measures: Providers

Alternate Core Measures
Preventive Care and Screening: Influenza Immunization for Patients -> 50 Years Old.-
Weight Assessment and Counseling for Children and Adolescents.
Childhood Immunization Status.

Hospitals



Hospital Quality Measures

- Emergency Department Throughput – admitted
- patients Median time from ED arrival to ED departure for admitted patients
- Emergency Department Throughput – admitted
- Patients Admission decision time to ED departure time for admitted patients
- Ischemic stroke – Discharge on anti-thrombotics
- Ischemic stroke – Anticoagulation for A-fib/flutter
- Ischemic stroke – Thrombolytic therapy for patients arriving within 2 hours of symptom onset
- Ischemic or hemorrhagic stroke – Antithrombotic therapy by day 2
- Ischemic stroke – Discharge on statins
- Ischemic or hemorrhagic stroke – Stroke education
- Ischemic or hemorrhagic stroke – Rehabilitation assessment
- VTE prophylaxis within 24 hours of arrival
- Intensive Care Unit VTE prophylaxis
- Anticoagulation overlap therapy
- Platelet monitoring on unfractionated heparin
- VTE discharge instructions
- Incidence of potentially preventable VTE

Other Important Provisions of the Rule

- **Limits on States' ability to deviate from this rule for the purposes of Medicaid Incentives.**
- **Provider protections:**
  1. **Ability to not report on up to five core objectives.**
  2. **Protection for measures that the provider cannot control.**
- **Method of Reporting – For providers and hospitals, in both programs, it's attestation.**

Clinics and Medical Groups

- Assignment of incentive payments – At the Provider's discretion.
- Practice-level calculation of patient volume.
- Physicians who practice at multiple locations.

Regional Extension Centers (RECs)

Federally-funded non-profit entities that assist providers in implementing EHR systems in their practices. There are four in California:

1. **CalHIPSO (Northern California): Rural North, Sacramento, Bay Area, Central Coast and Upper Central Valley**
2. **CalHIPSO (Southern California): Lower Central Valley, Inland Empire, and San Diego**
3. **HITEC-LA (Los Angeles County)**
4. **Indian Health Service (Tribal Areas Only)**

Coffee Beans

Meaningful Use of Coffee Beans

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