The Centers for Medicare and Medicaid Services (CMS) eHealth Summit
December 9, 2013

Overview

CMS' Second eHealth Summit took place on December 6, 2013. The Health care industry leaders discussed topics on four panels ranging from Stage 3 of Meaningful Use (MU), to the future of quality reporting, to health information exchange, and innovations happening at the state level. Visit the CMS website for a video recording of the event and the agenda.

Opening Remarks

Robert Tagalicod, Director of the Office of eHealth Standards and Services at CMS, provided the key dates for the health IT community to look forward to in 2014:

1. January 1st:
    a. Effective date of Administrative Simplification operating rules for electronic funds transfers (EFT) and remittance advice.
    b. Start of Stage 2 for EPs beginning their 3rd or 4th year of participation in MU.
2. February 28th:
    a. Deadline for Eligible Professionals (EPs) to submit 2013 Physician Quality Reporting System (PQRS) data through some reporting methods for the 20013 program year.
    b. Last day for Medicare EPs to register and attest for 2013 MU.
    c. Last day for Medicare EPs participating in the Electronic Reporting Pilot to submit quality data to satisfy both the PQRS and the Clinical Quality Measure. (CQM) requirements of MU
3. October 1st:
    a. Compliance date to transition from ICD-9 to ICD-10-CM/PCS for diagnoses and inpatient procedures.

The goal of CMS's eHealth Initiatives is to build a national health IT infrastructure to achieve the paradigm shift of increasing health care access, improving the quality of care delivered, and lowering cost in our health care system.

Panel 1: Health IT Innovation in Care Delivery Transformation, Payment Reform, and Population Health Management

Moderator: Ahmed Haque, Health IT Advisory at the Center for Medicare & Medicaid Innovation (CMMI), CMS

Panelists:

Craig Behm, Executive Director of MedChi Network Services, is the executive director of three advanced payment Accountable Care Organizations (ACOs) in Maryland that range from 5500 – 10,000 ACO beneficiaries. The ACOs are all primary care physicians and

community practices and were assisted by the CMMI advance payment funding. Mr. Behm explained that a paradigm shift is occurring in the provider environment. Physicians are thinking about population health management and team building. Although, physicians are feeling overwhelmed with the numerous initiatives and reporting requirements, the hope is that in three years, the process will be less overwhelming and Health Information Exchanges (HIEs) will be operating fully to allow providers tools in improving care.

Eurgene Heslin, MD, Head Physician at Bridge Street Medical Group, spoke about the Patient-Centered Medical Home (PCMH) model. Bridge Street Medical group is a top level 3 PCMH. His team has seen improvement in care coordination through the PCMH model; however, the challenge is that the systems are not intuitive yet. The IT systems need to communicate and become integrated in with provider workflow.

David Horrocks, President and CEO of Chesapeake Regional Information System for our Patients (CRISP), presented an overview of CRISP's achievements as a Health Information Exchange (HIE) for the state of Maryland. CRISP provides three core services to all hospitals and providers connected to the HIE.

1. Query Portal: Clinicians are able to pull patient health information from the HIE
2. Encounter Notification Service: when a patient enters a hospital or sees another provider, the primary care physician is notified
3. Reporting Services: CRISP provides the stakeholders with reports on items such as readmission and quality indicators.

When asked what processes need to be in place to enhance care coordination, Mr. Horrocks explained that many ideas are out there, however, an idea to improve the system will occur at the intersection of these three achievements:

1. When an idea is technically feasible
2. The idea will benefit the patient
3. All stakeholders involved will see a financial benefit to the idea.

Steve Maier, Health Care Reform Manager at the Department of Vermont Health Access, explained the distinguishing factors the state of Vermont has undertaken to improve health services in the community. First, Vermont has implemented the PCMH primary health care model, which is managed and developed by National Committee for Quality Assessment (NCQA). Second, Vermont has undergone payment reform to pay for quality of care rather than the volume of patients. In the PCMH model, providers are paid based on their NCQA scores for PCMH. As well, private and public payers have access to support this payment model. Third, Vermont has a statewide insurance information network and clinical data registry where health information can be presented in actionable ways to providers and patients.

Mr. Maier made it clear that CMS needs to engage with Substance Abuse & Mental Health Services Administration (SAMHSA) for substance abuse data. Change in patient outcome will improve with the inclusion of exchange with data around addiction.

<u>Panel 2: Trends in Health Information Exchange Organizational Staffing</u>

Moderator: Robert Anthony, Deputy Director, HIT Initiatives Group, CMS

The panelists collaborated to present the 2012 American Health Information Management (AHIMA) and Health Information Management Systems Society (HIMSS) joint study on health IT staffing. The study's purpose was to develop an environmental scan of staffing models for HIEs and care providers to determine the kind of job positions, roles, and responsibility the health IT industry needs.

Panelists:

Scott MacLean, Deputy CIO and Director at Partners HealthCare & Chairperson of the Board of Directors at HIMSS, started with providing statistics on the health IT staffing needs:

- The Bureau of Labor estimated a total of 51,000 of Health IT staff is needed.
- A total of $118 million was allocated to Health IT and Health Information Management education.
- In 2013: 20,000 health IT staff have been filled, leaving 31,000 positions still open. The Bureau of Labor estimates an additional 35,000 Health IT staff is needed in addition to the 31,000 left.

Charlie Rogers, CEO of Core Health Technologies & Health Information Exchange Committee at HIMSS, went over the current challenges in staffing:

- Top staffing challenges:
  - Need employees with skills in data integration and software support roles
- Top operations staffing challenges:
  - Need employees with skills in executive management and Master Patient Index Functions
- Overall staffing challenges:
  - Lack of available candidates
  - Lack of health IT organizations seeking security roles

Meryl Bloomrosen, Vice President of AHIMA, further explained the structure of the survey. A total of 35 Health Information Organizations (HIOs) participated in the survey. The purpose is to find what kind of skills, knowledge, and education is needed for employment in HIOs from the AHIMA & HIMSS study data. Ms. Bloomrosen explained that in order to overcome the staffing challenge, we need to answer the question: do we have the right people and skills to get to the goal? To find the answer, the survey included questions focused on understanding the HIO business model and how HIOs will sustain their organization in the future.

Cynthia Hilterband, Director of Yeaman and Associates, & HIE Network Coordinator at Greater Oklahoma City Hospital Council, explained what the actual positions and skills the HIE workforce needs:

- Top technical jobs in Demand:
  - Out of the 12 skills, Data Integration & Help Desk and Support were most in demand
  - Only 3 of the respondents reported security skills as important
- Operational jobs in demand:
  - Skills sought out: Executive Management, Finance, and Marketing

The study recommends for HIOs and HIEs to:

- Connect with professional organizations to reach largest possible pool of relevant candidates
- Plan ahead in filling key positions and consider creative staffing options
- Engage in social media
- Keep in mind of the evolutionary path of HIOs/HIEs to determine the staffing needs in the future

When asked what HIOs can do to maintain sustainability, the panelists responded with the following items:

- A strong HIO is dependent on strong, educated, top employees
- Need to bring interest to the younger generation as mobile and telehelath applications take off.
- HIOs need consumer engagement to be the driver of demand. This is what the panelists hope to see in MU Stage 2.

Panel 3: Stage 3 Meaningful Use

Moderator: Devin Jobb, President and CEO of Workgroup for Electronic Data Interchange, asked the panelists what are their lessons learned from MU Stage 1 and Stage 2 as well as their thoughts on Stage 3.

Panelists:

David Chou, MD, CTO, Information Technology Services and a UW Medicine Professor Lab Medicine at the University of Washington (UW), explained UW's Medicine health system transition in the different stages of Meaningful Use. Mr. Chao's team joined the Meaningful Use program in 2010.

His lessons learned from Stage 1:

- Getting attention of organization takes time
- MDs did not understand what was needed
- It took time to build the team with the right skills
- We had the same trouble spots as everyone else with changing workflows.

Looking at Stage 2, Mr. Chao said, "in retrospect, stage 1 was relatively easy." His team's Stage 2 challenges include:

- Organizational issues: Direct protocol required lots of communication within the community
- A vendor specific model that seems to be occurring with interchange of records
- The code for stage 2 is being upgraded very rapidly and requires testing
- Lack of clarity for many activities (e.g., how do we maintain Direct addresses)
- Resource conflicts with MU, ICD10, ePrescribing (eRX), PQRS, etc.

Stage 3 thoughts:

- Stage 3 objectives support improved outcomes, although it will require significant effort to achieve in an allowed timeframe
- Expect more organizational, workflow, and implementation challenges with wider requirements
- Increased CQMs challenges workflows

- MU Stage 3 does not consider other organizational needs differed by MU Stage 1 & 3 (replace obsolete systems, integrate new systems, mergers and acquisitions, etc.)
- Requirements challenge providing care to the underserved.

Mr. Chao's key takeaways and recommendations to the program:

- MU steps are 2 year cycles, but the implementation requires more than 5 years in Stage 2 and possibly more in Stage 3
- MU requires dictate "what"; EHR vendors and users must determine "how", a challenging and transformative process
- Time does not allow for reengineering an hardwiring workflows
- Multiple and conflicting mandates (e.g., ICD-10, CQM, and PQRS)

Mr. Chao stated that the biggest problem in MU is the lack of understanding provider workflow. IT software must match the design of the workflow.

Linda Fischetti, Care Delivery, Accountable Care Solutions, Aetna, provided a payer perspective of Meaningful Use. Ms. Fischetti stated that our priority and efforts should be focused on efficient quality reporting and data exchange requirements. Looking forward, here are a few opportunities MU, Ms. Fischetti explained can improve on to support change:

- Encourage payment and delivery innovation and reward provider efficiency
    - Provide incentives for interoperability
    - Improve the financial incentives for ACOs to assume risk. And reward those providers that do share risk
- Improve Quality and Accountability
    - Streamline high-value quality measures
    - Offer flexibility to ACOs in meeting MU standards
    - Extend Stark Anti-Kickback Safe Harbor exceptions

Shiv Gopalkrishnan, VP and General Manager, Health System Solutions, General Electric, provided a vendor perspective of MU. Here are his key leanings from stage 1 and stage 2:

- MU program has driven adoption and we are moving towards an increasingly digital ecosystem and data is becoming liquid
- The Office of the National Coordinator for Health Information Technology (ONC) and CMS staff and leaders are engaged and responsive
- Vendors and providers are focused on MU, but also have other Helath IT and EHR priorities, such as ICD-10, Accountable and integrated care, usability.
- MU 1 & 2 are complex programs: each measure has detailed specifications.
- Timing is tight for vendors & providers: this is reflected in concerns with Stage 2 certified product availability and implementation timing.
- Sources of provider burden and uncertainty revolves around "all or nothing" scoring, measurement challenges, and audit concerns

In regards to Stage 3, Mr. Gopalkrishnan's future recommendations are:

- Stage 3 should start no sooner than 3 years after the start of Stage 2
- CMS and ONC should provide a clear Stage 3 timetable to providers and vendors ASAP
- All required materials should be available no later than 18 months before the start of Stage 3
- Do not add many new additional MU requirements or certification criteria

- Avoid adding emerging functionalities not well-defined or standardized by the market or typically In EHRs (e.g. advance population health management tools.
- Reconsider all or nothing approach for attestation.

Robert Tennant, MA, Seniro Policy Advisory, Medical Group Management Association, provided the physician perspective of lessons learned in MU:

- Medical groups are, in general, very supportive of the adoption of EHRs.
- The incentive payments are a clear "sweetener," although it does not cover the cost of a typical EHR to install
- A significant percentage of EPs have attested under Stage 1 of the MU program. The MU program is working.

Physicians are concerned about the following issues:

- It's a challenging current environment for EPs and vendors(health insurance exchange, ICD-10, etc.)
- Redundant requirements
- MU criteria is weighted toward primary care
- "all or nothing" approach
- All year reporting. This does not take into account the realities of current practices with staffing issues, connectivity problems. Recommend having 10-20% of no reporting time in a year.
- Insufficient time for software developers and EPs to move from one stage to another

His suggested modifications to MU include:

- Easing the reporting burden – allow group MU reporting as is done with PQRS
- Avoid multiple reporting of the same quality data
- Permit flexibility in achieving MU (criteria/time)
- Avoid measures that require action by 3rd parties (patients, other care settings)
- Permit the "unforeseen circumstances" hardship category to include vendor-related problems
- No penalties for Stage 1 attesters
- "Engage" patients, don't force them
- Expand funding for the Regional Extension Centers (RECs) and allow them to assist for Stage 2 & 3 and in other Health IT areas.

Panel 4: eReporting, eMeasures, and the Future of Quality Measurement

Moderator: Kate Goodrich, MD, Director of Quality Measurement and Health Assessment Group at CMS, provided a background on electronic clinical quality measurements (eCQMs). eCQMs are standardized performance measurements derived from electronic health records. CMS provides a detailed measurement management timeline for eCQMs on their website. Ms. Goodrich asked the panel, what are their roles in the pathway of creating and implementing eCQMs?

Panelists:

Minet Javellana, RN, Division of Electronic Clinician Quality at the Office of Quality Measures and Health Assessment Group and the Center for Clinical Standards and Quality at CMS, explained the beginnings of measurement development. Measurements are created by public input and CMS contracts with measure developers, such as

Mathematica Policy Research, to lead the way. For MU Stage 3, CMS will be implementing a new "lean" measure development process. For each set of measures, CMS will take 1 or 2 measurements to put them through the implementation lifecycle and gather the results to find where are areas of waste and how to improve on the process. Afterwards, another batch of 1 or 2 measures will be proceeding with the new adjustments.

Cynthia Cullen, MBA, Principal Program Analyst at Mathematica Policy Research, explained the pathway as a measure developer. Mathematica works to align the measures with the National Quality Strategy. Then the measure moves into the "measure specification process," where Mathematica will talk to other stakeholders, including vendors and providers, to further define the measurement. The next step is testing where Mathematica will put the measure into a clinical reporting environment and gather field data. Finally, Mathematica will publish the measure into the eCQM program and hand it over to the vendors.

Ginny Meadows, RN, Executive Director of Corporate Strategy and Business Development at McKesson Corporation, provided a vendor point of view. She explained that the challenge is that vendors often don't get measures till late in the game. Vendors need the fully detailed measure specification publication to know how to implement the measure into the software. Once it is received, the vendor will perform an analysis of what data is required from their EHR in order for the providers to collect and fulfill the measure. This can be a timely process, Ms. Meadows explained.

Mickey McGlynn, Senior Director of Strategy and Operations at Siemens Medical Solutions & Chairperson of the Electronic Health Record Association, continued on the vendor perspective to elaborate on the certification process. eCQMs are now included into the certification process. She recommended for the community to step back and look at how we can efficiently accomplish the eCQM certification together.

Frederick Bloom, Jr., MD, Chief of Care Continuum at Geisinger Health System & Medical Director of Geisinger Health Plan, delivered a provider perspective of eCQMs. He stated that the benefit of a provider having accurate clinical information is absolutely critical in delivering care. However, there are implementation challenges and burdens to the providers. This includes the high cost and resources to implement the measures and adapt the reporting procedures.

Visit the CMS website for a video recording of the eHealth Summit and the agenda. For questions pertaining to this summary, please contact Nadeen Siddiqui at nadeen.siddiqui@ehidc.org