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Redesigning Workflow and Practice Components to Comply with Meaningful Use Regulations

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Speaker Biography

- Partner of Cumberland Consulting Group
- 25 years of consulting experience
- Former Partner with Ernst & Young, Vice President with Cap Gemini Ernst & Young and Delivery Executive with EDS
- Focuses on implementing practice management and electronic medical records systems for ambulatory providers including community health centers and Federally Qualified Health Centers to improve patient care and increase health center revenue
- Experience using application software to drive clinical and operational process improvement

Cumberland Consulting Group Overview

- Based in Brentwood, TN, Cumberland is a national technology implementation and project management firm serving ambulatory, acute and post-acute providers
- Cumberland is a member of the Tennessee Primary Care Association and the National Association of Community Health Centers
- Cumberland provides three types of services:
  - Strategic Information Technology Planning
  - System Selection
  - System Implementation
- Selected CHC Clients:
  - Unity Health Care, CHCANYS, Tennessee Primary Care Association, Community Health Centers (FL), D.C. Primary Care Association, HCNNY, Whitman Walker, SOME, LCDP, Mary's Center, Family & Medical Counseling Svc., Bread for the City, Grace Hill Neighborhood Health Centers
- Named one of the Seven Small Jewels of the consulting profession and one of the top 10 small firms to work for in America by Consulting Magazine for the last three years

Presentation Overview

- Provide an overview of meaningful use criteria required to qualify for up to $63,000 in Medicaid reimbursements under the American Recovery and Reinvestment Act of 2009 (ARRA)
- Examine workflow redesign and steps toward achieving meaningful use compliance, while also improving patient safety, care and efficiency

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Meaningful Use Incentives

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Meaningful Use Incentives

- On July 13th, 2010, the final ruling for the first stage requirements of Meaningful Use (MU) of electronic health records was released, which outlines the criteria eligible professionals and hospitals must meet through 2011 and 2012 in order to qualify for stimulus dollars
- Medicaid
  - Requires >30% of patient population are "needy individuals"
  - Incentive payments begin in 2011
  - Incentive limit is equal to 85% of "net average allowable costs"
  - In the first qualifying year demonstration of an effort to adopt, implement or upgrade a certified EHR is the only requirement
- Needy individuals include individuals who:
  - Receive assistance under Medicaid
  - Receive assistance under the SCHIP
  - Receive uncompensated care from the provider
  - Receive reduced charges by the provider on a sliding scale basis based on the patient's ability to pay
- Eligible Professionals may receive payments from Medicare or Medicaid, but not both. This presentation is focused on Medicaid payments

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Net Average Allowable Costs

- **Average allowable costs** = The average first year costs for the purchase or upgrade of EHR technology + subsequent year costs associated with the maintenance, operation and use of the EHR technology
- Payments received by providers from other sources (i.e. federal grants) are then **subtracted** from the average allowable cost, creating the **net average allowable costs**
- Providers may collect up to 85% of the net average allowable costs, which cannot exceed $25,000 in the first year, or $10,000 in the 5 subsequent years
- Incentive payments for the first year are intended to cover the purchase or upgrade of the EHR system and will not be distributed after 2016
- The incentive payments for each subsequent year may not be distributed after 2021 and may only be distributed for a total of five years

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Medicaid Payment Schedule for Eligible Professionals

Starting Year*	Maximum Payment Amount*											TOTAL
	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	
2011	$21,250	$8,500	$8,500	$8,500	$8,500	$8,500	$0	$0	$0	$0	$0	**$63,750**
2012	-	$21,250	$8,500	$8,500	$8,500	$8,500	$8,500	$0	$0	$0	$0	**$63,750**
2013	-	-	$21,250	$8,500	$8,500	$8,500	$8,500	$8,500	$0	$0	$0	**$63,750**
2014	-	-	-	$21,250	$8,500	$8,500	$8,500	$8,500	$8,500	$0	$0	**$63,750**
2015	-	-	-	-	$21,250	$8,500	$8,500	$8,500	$8,500	$8,500	$0	**$63,750**
2016	-	-	-	-	-	$21,250	$8,500	$8,500	$8,500	$8,500	$8,500	**$63,750**
2017	-	-	-	-	-	-	$0	$0	$0	$0	$0	**$0**

* Calendar Year

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Meaningful Use Criteria

Health Information Technology for Economic and Clinical Health (HITECH) Act Background

- Part of American Recovery and Reinvestment Act (ARRA) enacted on February 17th, 2009
- Initial set of Standards, Implementation Specifications and EHR Certification Criteria available for public inspection on December 30, 2009
  - Proposed definition of EHR certification
  - Proposed definition of Meaningful Use
    - Three stages over 5 years – 2011 through 2015
- Stage 1 Meaningful Use final ruling issued on July 13, 2010
  - Relaxed some requirements and provided additional flexibility
  - Revised to leave open the number of future stages and dates

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Summary of Meaningful Use

- In the Stage 1 final regulation, Meaningful Use elements are divided into two groups:
  - Core objectives – starting point for meaningful use of EHRs (**all must be met**)
  - Menu set – an à la carte menu of ten additional tasks from which providers can **choose any 5** to implement in 2011 and 2012

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Meaningful Use Core Set Objectives

- These objectives are to be achieved by all eligible professionals and hospitals in order to qualify for incentive payments

Summary Overview of Meaningful Use Objectives.*

Objective	Measure
Core set†	
Record patient demographics (sex, race, ethnicity, date of birth, preferred language, and in the case of hospitals, date and preliminary cause of death in the event of mortality)	More than 50% of patients' demographic data recorded as structured data
Record vital signs and chart changes (height, weight, blood pressure, body-mass index, growth charts for children)	More than 50% of patients 2 years of age or older have height, weight, and blood pressure recorded as structured data
Maintain up-to-date problem list of current and active diagnoses	More than 80% of patients have at least one entry recorded as structured data
Maintain active medication list	More than 80% of patients have at least one entry recorded as structured data
Maintain active medication allergy list	More than 80% of patients have at least one entry recorded as structured data
Record smoking status for patients 13 years of age or older	More than 50% of patients 13 years of age or older have smoking status recorded as structured data

Meaningful Use Core Set Objectives (cont.)

Summary Overview of Meaningful Use Objectives.*	
Objective	**Measure**
Core set†	
For individual professionals, provide patients with clinical summaries for each office visit; for hospitals, provide an electronic copy of hospital discharge instructions on request	Clinical summaries provided to patients for more than 50% of all office visits within 3 business days; more than 50% of all patients who are discharged from the inpatient department or emergency department of an eligible hospital or critical access hospital and who request an electronic copy of their discharge instructions are provided with it
On request, provide patients with an electronic copy of their health information (including diagnostic test results, problem list, medication lists, medication allergies, and for hospitals, discharge summary and procedures)	More than 50% of requesting patients receive electronic copy within 3 business days
Generate and transmit permissible prescriptions electronically (does not apply to hospitals)	More than 40% are transmitted electronically using certified EHR technology
Computer provider order entry (CPOE) for medication orders	More than 30% of patients with at least one medication in their medication list have at least one medication ordered through CPOE
Implement drug–drug and drug–allergy interaction checks	Functionality is enabled for these checks for the entire reporting period
Implement capability to electronically exchange key clinical information among providers and patient-authorized entities	Perform at least one test of EHR's capacity to electronically exchange information
Implement one clinical decision support rule and ability to track compliance with the rule	One clinical decision support rule implemented
Implement systems to protect privacy and security of patient data in the EHR	Conduct or review a security risk analysis, implement security updates as necessary, and correct identified security deficiencies
Report clinical quality measures to CMS or states	For 2011, provide aggregate numerator and denominator through attestation; for 2012, electronically submit measures

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Meaningful Use Menu Set

- Eligible professionals and hospitals may select any five choices from the menu set

Summary Overview of Meaningful Use Objectives.*	
Objective	**Measure**
Menu set	
Implement drug formulary checks	Drug formulary check system is implemented and has access to at least one internal or external drug formulary for the entire reporting period
Incorporate clinical laboratory test results into EHRs as structured data	More than 40% of clinical laboratory test results whose results are in positive/negative or numerical format are incorporated into EHRs as structured data
Generate lists of patients by specific conditions to use for quality improvement, reduction of disparities, research, or outreach	Generate at least one listing of patients with a specific condition
Use EHR technology to identify patient-specific education resources and provide those to the patient as appropriate	More than 10% of patients are provided patient-specific education resources
Perform medication reconciliation between care settings	Medication reconciliation is performed for more than 50% of transitions of care

Meaningful Use Menu Set (cont.)

Summary Overview of Meaningful Use Objectives.*	
Objective	**Measure**
Menu set	
Provide summary of care record for patients referred or transitioned to another provider or setting	Summary of care record is provided for more than 50% of patient transitions or referrals
Submit electronic immunization data to immunization registries or immunization information systems	Perform at least one test of data submission and follow-up submission (where registries can accept electronic submissions)
Submit electronic syndromic surveillance data to public health agencies	Perform at least one test of data submission and follow-up submission (where public health agencies can accept electronic data)
Additional choices for hospitals and critical access hospitals	
Record advance directives for patients 65 years of age or older	More than 50% of patients 65 years of age or older have an indication of an advance directive status recorded
Submit of electronic data on reportable laboratory results to public health agencies	Perform at least one test of data submission and follow-up submission (where public health agencies can accept electronic data)
Additional choices for eligible professionals	
Send reminders to patients (per patient preference) for preventive and follow-up care	More than 20% or patients 65 years of age or older or 5 years of age or younger are sent appropriate reminders
Provide patients with timely electronic access to their health information (including laboratory results, problem list, medication lists, medication allergies)	More than 10% of patients are provided electronic access to information within 4 days of its being updated in the EHR

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Meaningful Use Criteria by Payment Year

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

- In the first qualifying year only three months of meaningful use is required to qualify for incentive payments

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Achieving Meaningful Use: Workflow Redesign

Achieving Meaningful Use: Workflow Redesign

- Although your practice may currently be using a clinical documentation system, operational changes may still be necessary to change processes and workflow in order to properly capture and report data in alignment with MU requirements
- Although your EMR may be capable of capturing information required for MU criteria (e.g., smoking status), providers may not be capturing that information as part of an encounter
- Front-office staff may not be capturing demographic data appropriately in the system (i.e., in a structured format) to comply with MU reporting requirements
- To achieve meaningful use, a workflow redesign process may be required to ensure processes are aligned with practice management and clinical documentation standards defined in meaningful use criteria

Achieving Meaningful Use: Workflow Redesign

- Example 1: Patient registration practices may need some fine-tuning in order to **meet core measures of reporting at least 50% patient demographics as structured data** AND in order to **electronically submit accurate clinical quality measures to CMS or states**
- Capturing appropriate data begins at patient registration. It is important to train your staff to capture all required demographics (not dummy data) for your patient population in compliance with regulatory and funding sources

Considerations:

- Add required data elements to registration screens
- Develop appropriate training material and reinforce best practices for data capture
- If the data are not collected, you can't report on them

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Achieving Meaningful Use: Workflow Redesign

- Example 2: **Core Measure: More than 30% of patients prescribed meds must have at least one medication ordered through CPOE.**
- This often requires medical staff to change the way they document orders and prescribe medication
- Many physicians have difficulty transitioning from paper-based and verbal medication orders to CPOE
- It is important to develop a strong internal campaign and have appropriate staff champion these efforts in order to have all prescribing professionals on board
- Substantial redesign of current-state processes may be required to ensure the PM/EMR system is used in a "meaningful way"

Workflow Redesign Process

- Workflow redesign is not a difficult process, but it requires the right mix of executive sponsorship, engagement, focus and time to get it right
- Key ingredients to successful workflow redesign:
  - Executive leadership/sponsorship – Workflow redesign is a time-consuming effort that requires your experienced staff (who already have day jobs). Without executive sponsorship, the process will not have appropriate stakeholders involved
  - Experienced facilitation – Although your experienced staff provide the brain power, facilitators experienced with the process can educate your staff about the process and lead the effort
  - Conduct focused design sessions – Set a limited agenda and focus on specific processes. Include appropriate stakeholders, but not too many (20 people in a design session is too many). Record off-topic issues (parking lot) and move on

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Key Ingredients (continued)

- Key ingredients to successful workflow redesign:
  - Assign pre-work – Collect pertinent information before the meeting (e.g., paper forms) so appropriate information is available in the meeting
  - Assign home-work – Personnel may be required to collect additional inputs or data collection following the meeting
  - Keep minutes – Parking lot issues, key decisions and follow-up items should be recorded and published to all participants. A single coordinator should keep track of issues and follow-up items
  - Include reference material – To clarify future-state processes and system features, have reference material (e.g., PM/EMR screenshots or live system screens) to demonstrate how the design session relates to the actual system usage
  - Discuss real-world scenarios – Test future-state processes to determine feasibility in actual patient encounters

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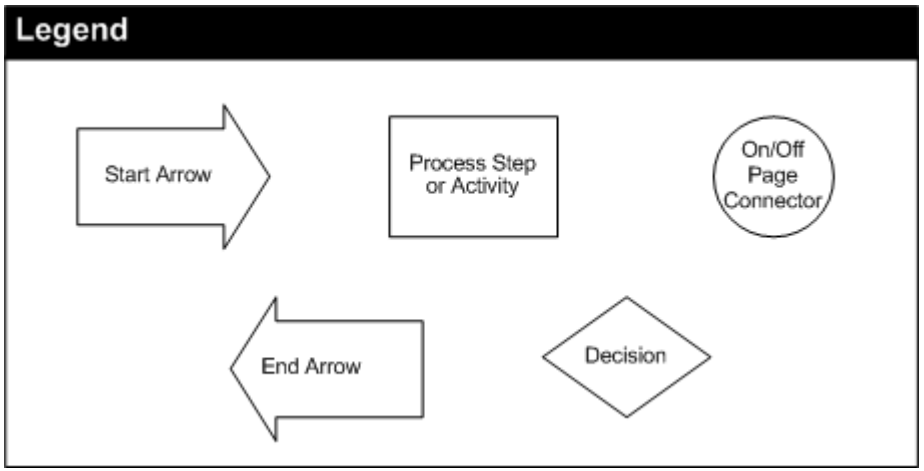
Workflow Documentation



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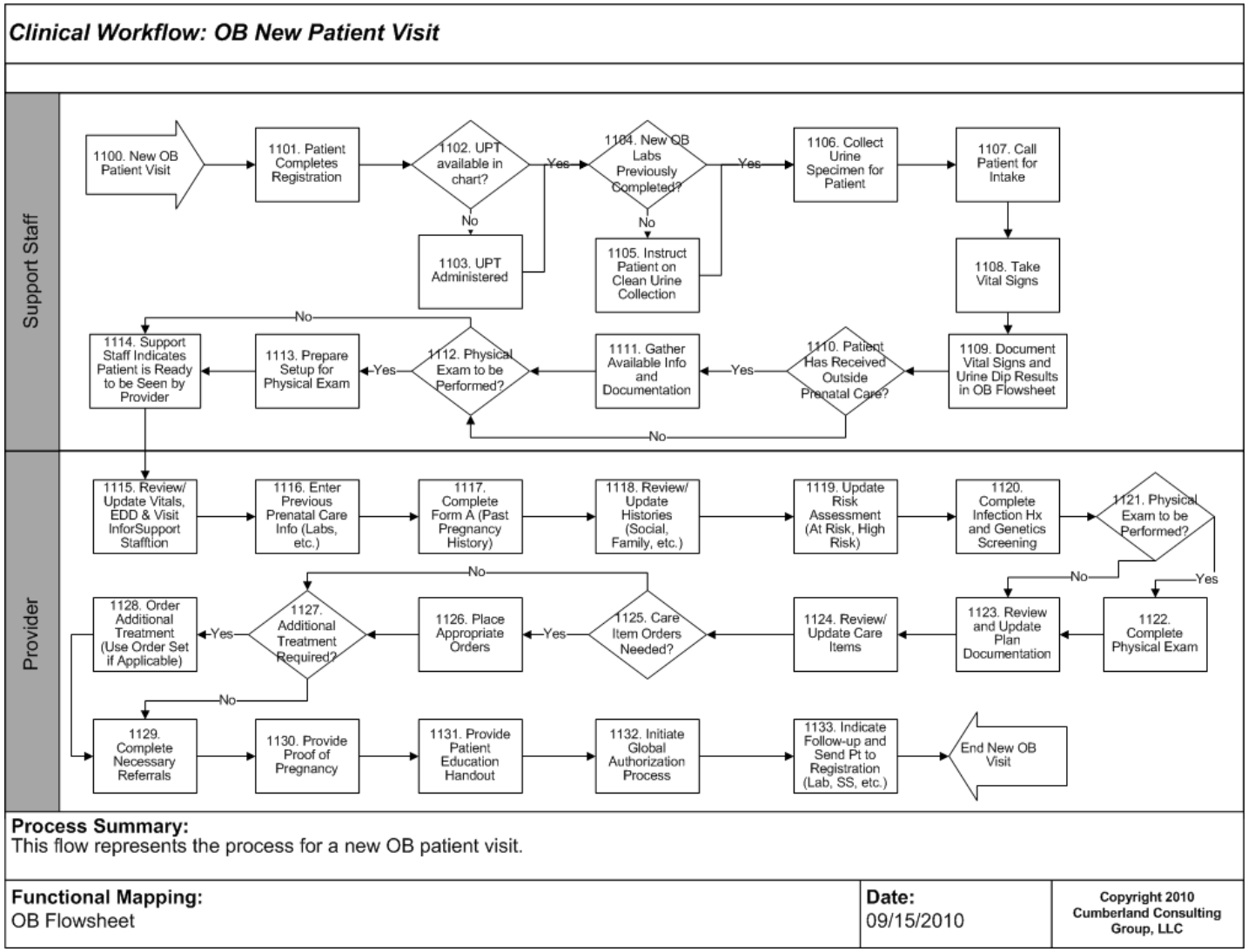
Workflow Redesign Output



Next Steps

- Validate design – Once future-state workflow is defined and documented by the design group, validate key workflow changes with additional stakeholders. Incorporate feedback into revised process flows
- Configure the system – Incorporate future-state workflows into the system according to the finalized workflow process maps
- Develop training curriculum – Develop training materials focused on how to use the system to accomplish future-state workflows. Trainers should fully understand the future-state workflows and ideally should have been involved in the workflow design process
- Incorporate new workflows into practice and measure change – Design measures to evaluate compliance with enhanced workflow design and determine corrective actions if necessary

Additional Considerations

Additional Considerations

- In addition to the workflow redesign process, several best practices will help you accomplish your goals and allow you to manage your project effectively

Appropriate Governance

- The first step should be recognizing EMR implementation is not simply a technology project, it is an organizational change that will likely require more time and resources than expected and will impact short-term productivity.
- Most issues can be addressed by an engaged executive team
- Without the full support of the executive staff the effort will be problematic. It is important to develop and enforce a strategic internal communications plan and company-wide campaign in support of the project

Considerations:

- Champion the project to reduce resistance
- Avoid low clinical adoption
- Set a course and lead the organization through the change

Build a Winning Team

- Some organizations spent years unsuccessfully trying to implement EMRs before securing the right resources.

A winning team consists of:

- Administrative and clinical personnel
- An experienced project manager (preferably a certified PMP) leading implementation
- A team with experience working in CHC / FQHC settings and experience with selected software
- Resources with exclusive focus (full-time) on implementation throughout the project and who report directly to the project team NOT in addition to their day-job

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Conduct a Objective Selection Process

- Before looking into a software system and walking through a demo, CHCs should undergo a requirements definition process
- Comprehensive assessment of your specific workflow, needs and services – in order to select an EMR system that will support your best practices and strategic initiatives

Considerations:

- Develop a weighted, objective scoring tool based on detailed requirements
- Run the selection as a project with clear objectives and milestones
- Include all appropriate stakeholders
- Vendors will demonstrate the best features of their application and downplay shortcomings
- Discovery-day process

Implementation NOT Installation

- Common misconception: Implementing EMR is a technology / IT department project
- Unlike simply installing a new software program, successful EMR implementations involve stakeholders from the entire organization and should be viewed as a major change in an organization's operations
- These projects are clinical quality and process improvement projects, the new software should be a byproduct of the process redesign effort

Considerations:

- Assembling a team of clinical, operational, administrative and IT stakeholders to remain engaged throughout the effort
- Determine project's real costs (hardware, software and services)
- Incentivize staff as appropriate

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