MONITORING NATIONAL IMPLEMNTATION OF HITECH: STATUS AND KEY ACTIVITY QUARTERLY SUMMARY

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Monitoring National Implementation of HITECH: Status and Key Activity Quarterly Summary: January-March, 2011
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This summary supports the global assessment by synthesizing in one place on selected statistics and activity reports relating to implementation of HITECH. It is developed quarterly and reflects information made available between January 1, 2011 and March 28, 2011. The list is not meant to be exhaustive but to reflect a subset of reports and activities captured by reports on the ONC or CMS web site, in selected documents that are referenced in the reports ONC receives daily as part of its communications monitoring, and selected other activities of which we are aware. We welcome additions and clarifications from ONC.

Meaningful Use Incentive Payments—Stage 1

- CMS Portal opened for Medicare incentives registration on January 3, 2011. (Medicare attestation starts mid to late April 2011 with first payment expected May, 2011. For schedule, See http://www.cms.gov/ehrincentiveprograms/#BOOKMARK3.

- CMS indicated in its February 23, 2011 release that over 21,000 providers had signed up for the Medicare or Medicaid program in January 2011. (http://www.tnrec.org/pr-022411-initial-registration-activities-reveal-strong-interest.html)

    - Press reports cite a CMS Twitter account saying CMS has also registered 25,217 eligible healthcare physicians and hospitals for its incentive programs, paying $37.6 million (posting in late March, unclear what this refers to) http://www.govhealthit.com/newsitem.aspx?nid=76833

    - CMS announces attestation for Medicare MU payments to open April 18, 2011 (http://www.healthdatamanagement.com/news/ehr-meaningful-use-medicare-attestation-42198-1.html)

- States use common portal to access state Medicaid sign up. States able to launch programs January 3, 2011 and begin payments immediately. CMS indicated on February 23, 2011 that 11 states had launched programs by then. See noted cite:[1]

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[1] http://www.cms.gov/apps/media/press/release.asp?Counter=3902&intNumPerPage=10&checkDate=&checkKey=&srchType=1&numDays=3500&srchOpt=0&srchData=&keywordType=All&chkNewsType=1%2C+2%2C+3%2C+4%2C+5&intPage=&showAll=&pYear=&year=&desc=&cboOrder=date

- Four states issued payments to at least one provider: Oklahoma and Kentucky (January 5), Louisiana, (January 12), Iowa (January 17).

- Other states with operational programs were: Alaska, Michigan, Mississippi, North Carolina, South Carolina, Tennessee and Texas.

- Schedule of expected starts for all states is available at: http://www.cms.gov/apps/files/medicaid-HIT-sites/. Our review on March 24, 2011 showed most states reporting their programs would become operational at some point in 2011 (mainly summer and fall). States that had an unknown reported data were: Colorado, Connecticut, DC, Georgia, Hawaii, Massachusetts, Maryland, New Jersey, New Mexico, Vermont, and West Virginia. (Montana showed a Spring 2011 anticipated launch but press reports indicated that Montana's legislature had rejected the program (and federal funds) though final action might be reversed by the Governor. http://ehrwatch.com/blog/drop-bucket-montana-gop-lawmakers-isnt-drop-bucket-healthcare-providers

  More than four in five office based physicians could qualify for MU payments according to a March 2011 *Health Affairs* study by Bruen et al. Based on analysis of NAMCS data, the study compares practice to threshold patient mix criteria for qualification. It found 90.6 percent of physicians in general/family practice or internal medicine qualifying but fewer than two thirds of pediatricians, ob/gyns and psychiatry. Pediatricians were particularly dependent on Medicaid. While over 80 percent of physician owned office practices coujld qualify, only 6.3 percent of those in solo practice and 16 percent in physician owned groups currently had at least a basic EHR. (94 percent of CHCS based physicians qualified) (http://content.healthaffairs.org/content/30/3/472.abstract?sid=dd0008e6-b8ab-4cb5-b78b-a146442a629e)

- Sen. Sheldon Whitehouse (D-RI) introduced The Behavioral Health Information Technology Act of 2011, which aims to expand eligibility for EHR incentives to mental health care providers and facilities. (http://www.healthcareitnews.com/news/bill-extend-mu-incentives-behavioral-healthcare-providers-facilities)

- Advisory Board recommends hospitals (and physicians too) wait for 2012 to demonstrate stage 1 MU incentives because not doing so is risky and there isn't anything to lose. (http://www.ihealthbeat.org/perspectives/2011/not-so-fast-why-it-pays-to-wait-until-fy-2012-on-meaningful-use.aspx)

Regional Extension Centers

- As discussed in the interdependency paper, this program has a national goal of signing up 100,000 primary care providers (out of an estimated 250,000 such eligible providers) in two years (we estimate this is about mid 2012 since most RECs were funded by early 2010.)

- ONC indicated that by February 11, 2011, more than 45,000 providers had requested information or registration help from the 62 RECs. (We are uncertain how to interpret this number vis a vis program goals). (See note 1 for link to cite).

- ONC has developed a "physician champion" program (the Meaningful Use Vanguard) to assist RECs in helping providers struggling with adoption. (www.govhealthit.com/newsitem.aspx.nid=76440)

- On January 27, 2010 ONC awarded $32 million in additional funds to accelerate outreach to providers to encourage registration in EHR incentive programs. On February 8, 2011, ONC awarded $12 million in supplemental funding to existing RECs support eligible critical access and rural hospitals in adoption EHR Technology.

Availability of Certified Products and the Vendor Market

- By the end of December 2010, ONC certified six organizations as authorized testing and certification bodies under temporary certification rules. Five are authorized to certify complete EHRS and EHR modules. (http://www.healthit.gov/policy-researchers-implementers/testing-laboratories-certification-bodies)

  o The Certification Commission for Health Information Technology (CCHIT) and Drummond Group were both certified on September 2, 2010 followed by InGard Laboratories on September 24, 2010, and SLI Global Solutions and ICSA Labs on December 10, 20100.

  o Surescripts LLC was authorized to review EHR modules relating to E-Prescribing and Privacy/Security on December 23, 2010.

- ONC issued the final rule for the permanent certification on January 2011 and will be transitioning to this program in 2012. (Existing certifications grandfather over but there may be some additional review to make sure they address expanded MU requirements.) http://www.healthcareitnews.com/news/onc-issues-final-rule-permanent-certification-program

- ONC leadership indicates that by February 2011, there were 450 certified electronic health record products offered by 280 companies - 64 percent of which have fewer than 50 employees. (http://thehill.com/blogs/healthwatch/health-reform-implementation/148045-top-health-technology-official-touts-success-as-he-steps-down)

- ONC has a web site that allows providers to search a complete list of certified products relating either to ambulatory care or to inpatient care. These indicate who certifies them, the vendor, the product and version, classification, and additional software needs. (http://onc-chpl.force.com/ehrcert)

- Kalorma, a market research firm, estimates EMR market has grown slower than expected in 2009 and 2010 (10% and 13.6 percent versus 15 percent predicted but still was $14.7 billion in 2010 with 50 percent of physicians using EMR. (http://www.informationweek.com/news/healthcare/EMR/229300131?queryText=EMR market , March 3, 2011 article))

- Big insurance companies (eg Aetna, UnitedHealthcare) are getting into the HIT market through acquisitions that will get them more involved with MD workflow (http://www.fiercehealthit.com/story/insurance-companies-leap-hie-field-will-change-health-it/2011-03-02)

- Largest vendors of ambulatory HIT are: All Scripts, (16% of deals), Epic (12%, esp. high in large practices), NextGen (10%, biggest 6-25 MD) and others. 35% of providers say they intend to replace their EHR over the next year, including "nearly a third" of small practices. Some are changing because of sunsetting current practice. (http://www.informationweek.com/news/healthcare/EMR/showArticle.jhtml?articleID=229300157&cid=RSSfeed_IWK_All)

Health Information Exchange

- ONC releases its five 7 year Federal HIT Strategic Plan (2011-2015) for public comment. The plan identifies five strategic goals over the period and means to achieve them. It includes: (1) achieve and adopt information exchange through MU of Health IT; (2) improve care, improve population health and reduce health care costs through the use of HIT; (3) inspire confidence and trust in Health IT; (4) empower individuals with Health IT to improve their health and the health care system; and (5) achieve rapid learning and technological advancement (http://www.healthit.gov/buzz-blog/from-the-onc-desk/hit-strat-plan/)

- On January 27, 2011, ONC announced the available of an additional $16 million (beyond the $80 million initially to HIEs for "challenge grants" to encourage breakthrough innovations for exchange that promote nationwide HIE and interoperability. (http://www.healthit.gov/providers-professionals/health-information-exchange-challenge-grant-program)
  The program was open to 10 grants of $1-$2 million to HIEs for work in five areas:

    1. Achieving health goals through health information exchange (North Carolina)
    2. Improving long-term and post-acute care transitions (Colorado, Maryland, Massachusetts, and Oklahoma)
    3. Consumer-mediated information exchange (Indiana, Georgia)
    4. Enabling enhanced query for patient care (Indiana)
    5. Fostering distributed population-level analytics (Montana)

- An advisory committee has identified recommendations for best practices and requirements for individual level provider directories or provider listings to promote exchange http://www.himss.org/ASP/ContentRedirector.asp?type=HIMSSNewsItem&ContentId=76404 Once they are approved by the policy committee, they will be translated into standards by the Standards committee. The committee recommended that the PECOS information CMS uses should be made available to support this.

- ONC has worked with others to develop the "Direct Project" , an "open government" open source software initiative to support simple exchange needed by providers. On February 2, 2011, ONC announced the launch of "Direct Project" pilots in Minnesota and Rhode Island. (http://www.hhs.gov/news/press/2011pres/01/20110202a.html)

  - The Minnesota project involves Hennepin Co. Medical Center (Minneapolis) sending immunization records to the Minnesota Department of Public Health.

  - The Rhode Island project is for the Rhode Island Quality Institute and supports provider to provider exchange to support referrals.

  - Other direct pilots are expected "soon" in New York, Connecticut, Tennessee, Texas and Oklahoma.

- ONC says that the Direct Project protocols for simple exchange have the support of over 60 health care organizations that represent 90 percent of the IT vendor market. More than 20 states are said to be participating in the project. (http://govhealthit.com/news/direct-project-gets-wide-support-simple-exchange)

- Indiana's HIE Quality Program is said to reach 1,500 physicians with over 1 million patients in over 50 communities. The focus is on improved screening rates and management of conditions. Anthem Blue Cross and Blue Shield of Indiana is awarding bonus payments based on health improvements. UnitedHealthcare and Unified Services Group, Medicare and Medicaid also participate. (www.fiercehealthcare.com/node/54442/print)

Privacy and Security

- The Office of Civil Rights has asked for a 13.7 percent increase in its FY 2012 funds for HIPPA enforcement. Article reports that as of September 30, 2010, OCR received 9,300 health information breach reports—191 affecting more than 500 individuals and 9,109 affecting fewer than 500 people. (https://home.modernhealthcare.com/clickshare/authenticateUserSubscription.do?CSProduct=modernhealthcare&CSAuthReq=1:373411559323425:AID|IDAID=20110317/NEWS/303179989|ID=:144A696C1CE0090C26ACE2F311372E0A&AID=20110317/NEWS/303179989&title=HITS%20Briefs1%20-%20HHS%27%20Office%20for%20Civil%20Rights%20wants%20more%20money%20to%20investigate%20data%20breaches&ID=&CSTargetURL=http%3A%2F%2Fwww.modernhealthcare.com%2Fapps%2Fpbcs.dll%2Flogin%3FAssignSessionID%3D373411559323425%26AID%3D20110317%2FNEWS%2F303179989)

- The IOM will soon be issuing a report based on a $989,000 million grant from ONC to examine the relationship between HIT and patient safety. (http://www.iom.edu/Activities/Quality/PatientSafetyHIT.aspx) (It is not clear whether this report is best viewed in this category versus overall context of quality work.)

- ANSI and the Shared Assessments Program are involved in estimating costs of security breaches for plans, providers, and health plans as well as the protections. ONC reports data on security breaches involving 500 individuals or more http://www.hhs.gov/ocr/privacy/hipaa/enforcement/data/complaintsyear.html

Workforce Programs

- On January 27, 2011, the community college programs were awarded $32 million in second year funding to continue HIT programs.

- No reports located about trainees etc.

Provider EHR Adoption, Other Sources of Support, and Issues

- NCHS released 2009 national data and preliminary 2010 state estimates on EMR systems in physician offices (http://www.cdc.gov/nchs/data/hestat/emr_ehr_09/emr_ehr_09.htm). Combined 2009 data show 48.3 percent of physicians using all or partial EMR/HER in office based practices. There were 21.8% with systems that met the criteria for basic systems and 6.9 percent that met criteria for fully functional systems in 2009. (The 2010 preliminary estimates show 50.7 percent, 24.9 percent and 10.1 percent respectively). Preliminary estimates for states in 2010 range from 38.1 percent to 80.2 percent, with 12.5 percent to 51.5 percent meeting basic system criteria (27 states had unreliable estimates for fully functional systems). States with significantly higher rates of adoption of at least a basic system were Washington, Oregon, Utah, North Dakota, Minnesota, Wisconsin, Iowa, New Hampshire and Massachusetts. States with significantly lower rates of adoption were Kentucky, Maryland, New York and Connecticut (check real data; map hard to distinguish).

- On February 1, 2011, CDC made a two year grant of $4.9 million to the AHA, American College of Pathologists, and SureScripts to help 500 or more hospitals transmit laboratory data to public health agencies in order to meet the public health reporting requirements for meaningful use. http://www.ama-assn.org/amednews/2011/03/07/bish0311.htm

- The California State Rural Health Association will work with United HealthCare to float a bond issue for $10 million to pay the upfront costs of adopting EHRs in six California critical access hospitals (hospitals estimate individual requirements at $1.5 to $2 million). A second issue will be for about $10 million for 14 hospitals. (www.modernhealthcare.com/article/20110304/BLOGS02/303049962?AllowView=) (Wellpoint also appears to have some involvement)

- ONC issued a press release on January 13, 2011 reporting surveys indicating that 4/5 of the nation's hospitals and 41 percent of office based physicians intended to sign up for incentive payments. More detailed data showed that 2/3 of the hospitals said they'd enroll in stage one. 1/3 of the physicians said they'd enroll in stage one. http://www.hhs.gov/news/press/2011pres/01/20110113a.html.

- CCHIT reported on a blog on results from a survey that had 468 responders that included providers, vendors and others. At least one third found the following too aggressive: syndromic surveillance, drug formulary checks, medication reconciliation, patient access to health information in 4 days, submission of immunization data, capability to exchange key clinical information, clinical decision support, submission of reportable lab data (and reconciliation with orders), drug allergy/etc checks (http://ehrdecisions.com/2011/03/03/from-the-chair-meaningful-use-stages-two-and-three/)

- In analysis of a 2008-2009 national survey of physicians, Wynia et al found 64 percent had never used a patient's electronic personal health record but 42 percent would be willing to try. Rural physicians were much more willing and female physicians less. Key concerns include privacy, accuracy, liability, and lack of payment for use. (http://content.healthaffairs.org/content/30/2/266.abstract?sid=22685105-f12f-4254-b3f1-de8822a2c381)

- On March 15, 2011, MGMA (Bill Jesse) wrote to Secretary Sebelius asking for help reconciling e Prescribing and Meaningful Use Incentives. They say the 2011 requirements of the two programs conflict, so providers can get MU payments and still be penalized for the same number of prescriptions on e prescribing. (http://www.mgma.com/WorkArea/DownloadAsset.aspx?id=41329) .

- Posting examines harmonization (or not) of MU, e-prescribing and PQRS (http://blog.srssoft.com/2011/03/meaningful-use-eprescribing-pqrs-need-for-harmonization/)

- Article by Fleming et al in March 2011 reports on financial and nonfinancial costs of implementing MU incentives in a five person physician office practice in Texas. (http://content.healthaffairs.org/content/30/3/481.abstract)

- Avaya survey of HIT professionals shows biggest future demand is for communication and workflow issues. (http://emrdailynews.com/2011/03/15/avaya-survey-reveals-healthcare-it-professionals%E2%80%99-opinions-on-latest-technologies-and-challenges/

- Metzger and Rhoads in a January 2011 report from the Computer Sciences Corporation analytze the data element requirements to meet meaningful use and what that means for a medical group. (http://www.csc.com/health_services/insights/58405-physician_quality_reporting_the_hidden_requirements_of_meaningful_use)

Development of Stage 2 Meaningful Use Requirements

- The HITECH legislation calls for implementation of Phase 2 meaningful use requirements effective October 1, 2012. The HIT Policy Committee (and its MU Workgroup) have been considering what to recommend for CMS consideration. Public Comments on these were elicited by the HIT Policy Committee, with a due date of February 25, 2011. The draft shows new requirements being considered in Stage 2 and 3 along with changes in current Stage 1 requirements. ONC reports it got 422 submissions in response. Providers and vendors generally wanted the October 1, 2012 date extended and consumers, IT purchasers, health plans, and HIT proponents wanted to say with current schedule. http://www.healthcareitnews.com/news/fed-advisors-tackle-stage-2-recs-and-timing

- o In a letter signed by the AMA and 28 other professional societies, physicians expressed concern that pushing too many requirements would create an onerous burden, especially for smaller physician practices. It called for surveying physicians about Stage 1 and recommended four other general principles in constructing future measures. (http://www.ama-assn.org/ama1/pub/upload/mm/399/comments-hitpc-proposed-measures-25feb2011.pdf)

- o Other influential stakeholders have posted comments on line and/or been quoted in the press including AHIMA submission on February 24, 2011 (technical comments plus alignment with other initiatives), HIMSS EHRA submission (options for dealing with timeframe concerns), eHealthinitiative (11 points that relate to learning, priorities, implementation etc) and a coalition of 25 consumer groups and unions asking federal officials to hold firm. (ONC Weekly Media and Blog Monitoring Report -- 2/25/11 to 3/4/11)

- o CCHIT reported on a blog on results from a survey that had 468 responders that included providers, vendors and others (29%). At least one third found the following too aggressive: syndromic surveillance, drug formulary checks, medication reconciliation, patient access to health information in 4 days, submission of immunication data, capability to exchange key clinical information, clinical decision support, submission of reportable lab data (and reconciliation with orders), drug allery/etc checks (http://ehrdecisions.com/2011/03/03/from-the-chair-meaningful-use-stages-two-and-three/).

- On March 22, 2011, members of the PCAST work group discussed the implications of the December 2010 report by the President's Council of Advisors on Science and Technology (PCAST). http://www.informationweek.com/news/healthcare/policy/showArticle.jhtml?articleID=229301296&cid=RSSfeed_IWK_News This report was critical of the ability to support meaningful exchange of health information in Phase 2 of MU requirements due to the lack of a standardized universal exchange language. (http://www.whitehouse.gov/sites/default/files/microsites/ostp/pcast-health-it-report.pdf)

Effectiveness of HIT

- The March 2011 issue of *Health Affairs* contains an article by Buntin et al that updates earlier syntheses of peer reviewed literature on the effectiveness of HIT for the period July 2007 up to February 2010. Of the 154 studies, 62 percent were rated as positive, which meant that HIT was found to improve one or more aspects of care, with none worse off and 92 percent were either positive (as before) or mixed-positive with a positive overall finding but at least one negative aspect found. Ten studies were categorized as having overall negative findings, mainly related to potential problems with implementation and use of HIT. Authors conclude that "human factors" are critical to HIT implementation and warrant additional consideration. (http://content.healthaffairs.org/content/30/3/464.abstract)

Other (Contextual etc)

- In March 2011, HHS released its mandated *Report to Congress: a National Strategy for Quality Improvement in Health Care.* It identifies three aims: better care, healthy people/healthy communities, and affordable care. HIT is cited as one of three example federal initiatives to promote effective communication and coordination of care.
(http://www.healthcare.gov/center/reports/quality03212011a.html#es)