

MICHIGAN HEALTH INFORMATION TECHNOLOGY COMMISSION

April 17, 2014

The Michigan Health IT Commission is an advisory Commission to the Michigan Department of Community Health and is subject to the Michigan open meetings act, 1976 PA 267, MCL 15.261 to 15.275



Agenda

- A. Welcome & Introductions
- B. Review & Approval of 3/20/2014 Meeting Minutes
- C. HIT/HIE Update
- D. Meaningful Use Discussion
- E. HITC Next Steps
- F. Public Comment
- G. Adjourn



Welcome & Introductions

- Commissioner Updates



HIT/HIE Update

Meghan Vanderstelt, MDCH



2014 Goals – April Update



Governance Development and Execution of Relevant Agreements

- Registration now open for Connecting Michigan (June 4-6 at Lansing Radisson)
- Lt. Governor Brian Calley presenting opening remarks, introducing keynote
- Use Case WG refining criteria to prioritize new use cases
 - 5 of 11 QOs sent in their initial high priority use case lists to MiHIN
- Privacy Working Group drafted educational framework for providers/patients for standard consent form for behavioral health (to present at May meeting)
- Privacy White Paper recommendation priorities collected (to present in May)
- Michiana HIN (MHIN) HIE-QO application reviewed by MiHIN Board
- MOAC Governance WG renamed “Issue Remediation Working Group (IRWG)
- Board resolution requiring DirectTrust accreditation for Direct Secure Messaging to/from MiHIN passed and to be announced

Technology and Implementation Road Map Goals

- Immunization history/forecast pilot with MHC / Athena scheduled in March has been delayed; a different HIE-QO may be selected for the pilot
- FY14 projects in progress: MiWay Consumer Directory, Identity Hub Pilot, Clinical Quality Measures Recovery and Repository (CQMRR aka “skimmer”)
- FY14 HIT APD projects starting Jun): MU Expansion, Statewide Health Provider Directory Expansion, Behavioral Health Information Exchange

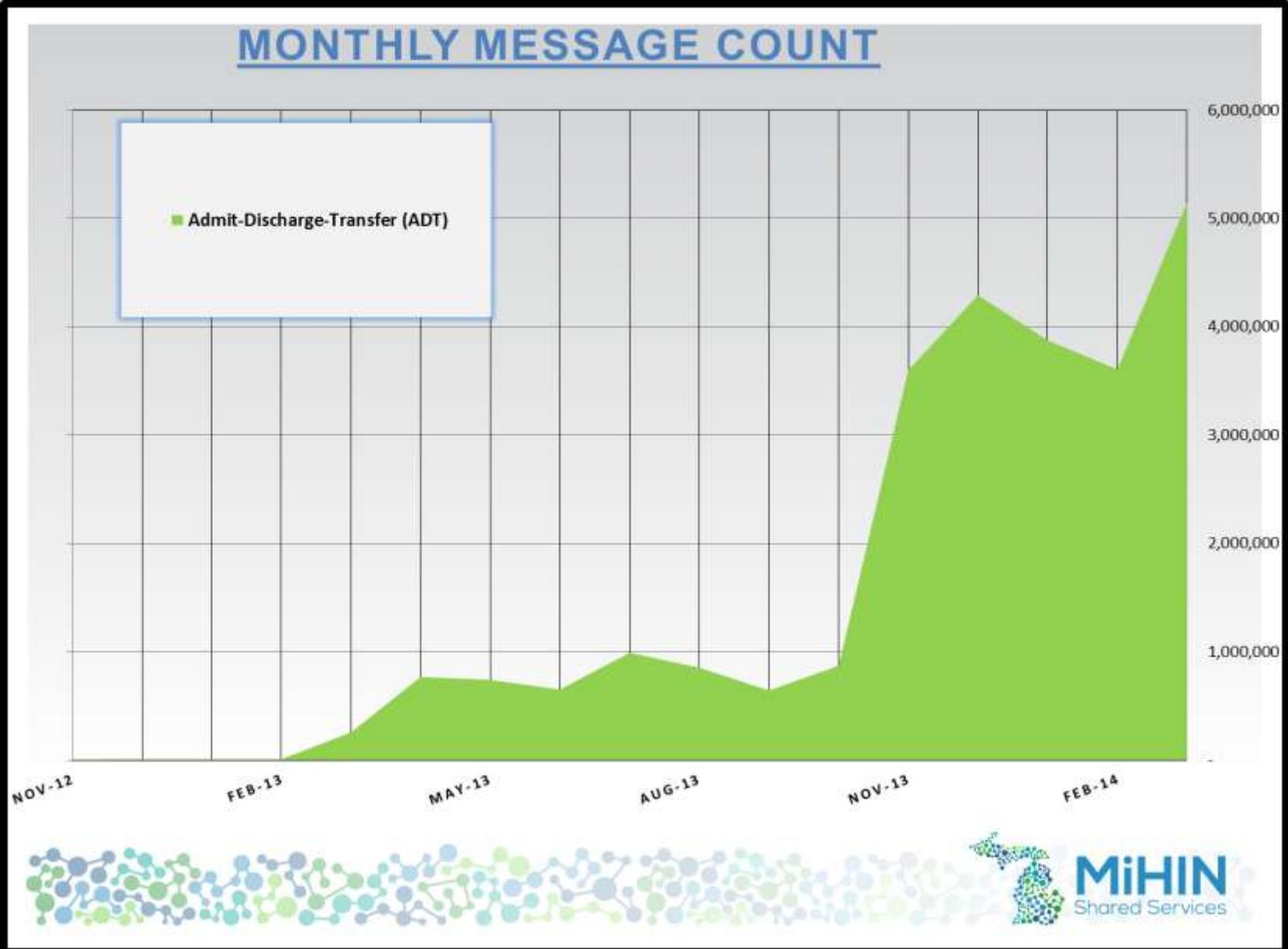
QO & VQO Data Sharing

- MiHIN received ADT messages for Henry Ford Health System hospitals starting March 23rd causing an increase of approximately 500,000 ADT messages for the reporting period; MiHIN now receiving > 5 million ADTs per month
- MiHIN receiving average of 1.25 million messages/week (ADTs, VXUs, ELRs)
- MiHIN received 216,349 syndromic surveillance messages from MHC and GLHIE
- Over 30 million messages received since starting production on May 8, 2012

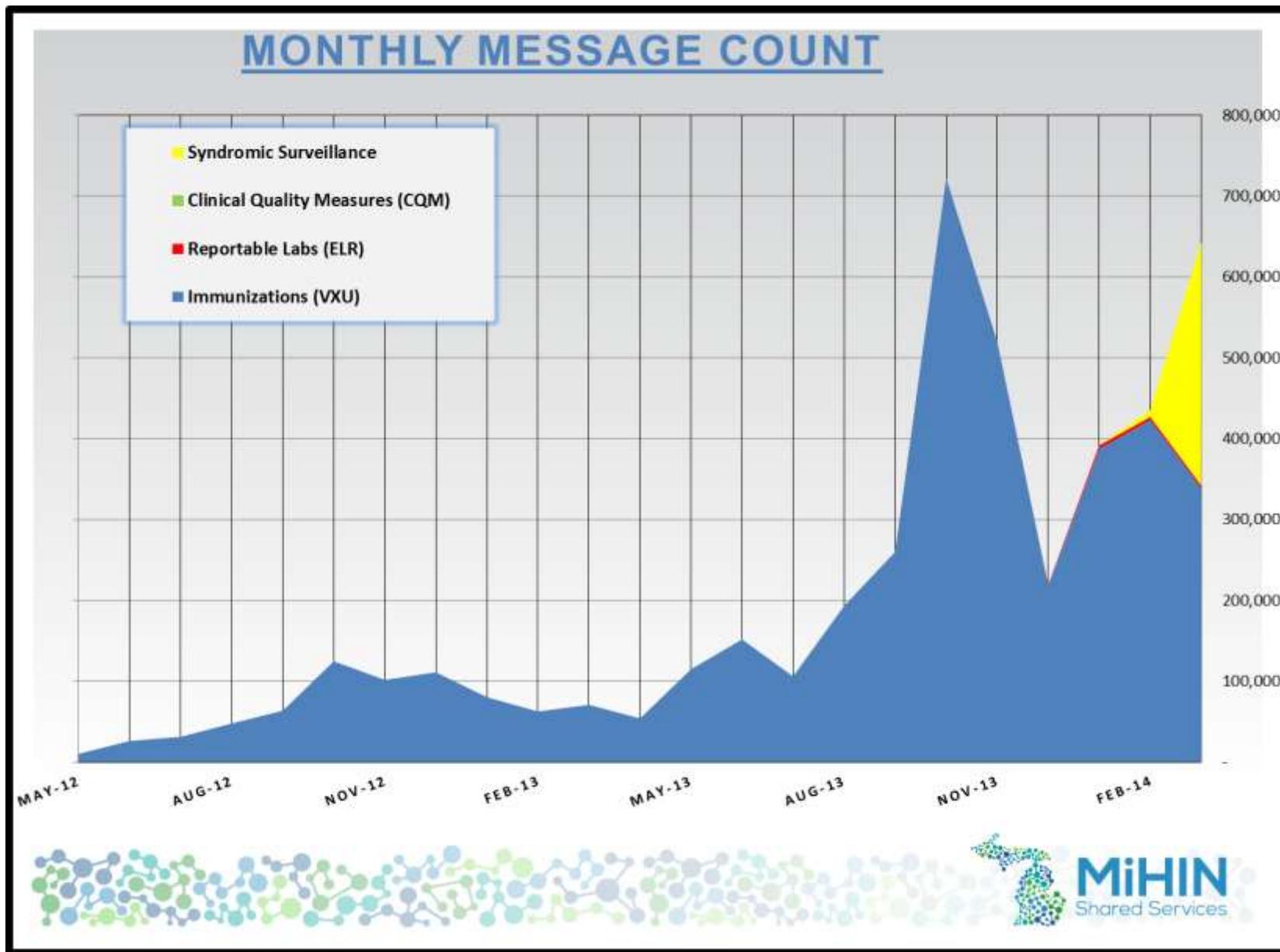
MiHIN Shared Services Utilization

- MHC, UPHIE, and MDCH in DQA with syndromics use case; GLHIE/UMHS next
- JCMR and Ingenium beginning Cross-QO Query use case!!!

Monthly Message Count



Monthly Message Count



MiHIN Monday Metrics (M3) Report

2 Week Total	Prod. Running Total**	Sources in Prod. Through MiHIN	Sources in DQA	QOs in production	QOs in test	vQOs in production	vQOs in test	Use Case
161,356	4,129,255	561	292	5	1			Immunization Records Submit (VXU)
1,173	11,668		60	2				Reportable Labs Summaries (ELR)
	6,047,338			2				Transition of Care - Payers/BCBSM (ADT)
2,215	257,824			1		1		Admit-Discharge-Transfer (ADT) Spectrum/Carebridge
2,736,461	20,068,268		11	3		1		All Patient- All Payer ADT Notification Service
				3				Submit Data to Active Care Relationship Service
								Submit Data to Health Provider Directory
216349	216349		1		3		1	Receive Syndromics
0	202							Clinical Quality Measures
3,117,554	30,730,904	561	364	16	4	2	1	Totals



MDCH Data Hub

April 2014

Production Updates

- **MPI (Master Person Index)** – Stakeholders are being scheduled to participate in comprehensive training sessions early to Mid May 2014. The sessions will provide the stakeholders (data stewards, the data owners and administrative support staff) insight on the terms, concepts and functionalities to increase their knowledge and understanding of the product in order for them to provide support for future projects such as work needed to add new data sources.

Technology Development/Implementation

- **MICAM (Michigan Identity Credentialing and Access Management)** - The MICAM team has completed initial functional and system requirements gathering sessions. The project schedule includes the work needed to integrate the Medicaid smart phone application 'MyHealthButton' (via MiPage) and a new web-based 'Member Portal'. The MICAM, MiPage, and MyHealthButton/Member Portal teams are currently reviewing schedule options to determine the appropriate Go Live date.

Technology Infrastructure Development

- **Cross-Community Clinical Document Service** – is planned development for FY14 and FY15 to implement infrastructure needed to share documents based on a query/retrieve model. Query/retrieve process involves three steps - patient discovery, document discovery, and document retrieval. This infrastructure is needed to accomplish the creation and delivery of Continuity of Care Documents (CCD) for the Medicaid Integrated Care for Dual Eligibles (ICDE) project.

Meaningful Use Registry Work

- **Bureau of Laboratories (BoL)** – As a requirement for Stage 2 MU, hospitals and providers are required to incorporate the receipt of clinical lab results into EHRs. Local Health Departments have requested the ability to receive lab results from the MDCH BoL's StarLims system. Work will commence to implement the already developed Send Lab Results HL7 message in FY14/FY15.



Current Participation Year (PY) Goals

	Reporting Status	Prior Number of Incentives Paid	Current Number of Incentives Paid	Current PY Goal Number of Incentive Payments	Current PY Medicaid Incentive Funding Expended
Eligible Provider (EPs)	AIU	624	730	1,003	\$13,260,000
	MU	903	903	1,043	\$7,675,500
Eligible Hospital (EHs)	AIU	-	-	15	\$ -
	MU	-	-	43	\$ -

Cumulative Incentives for EHR Incentive Program 2011 to Present

	Total Number of EPs & EHs Paid	Total Federal Medicaid Incentive Funding Expended
AIU	3,263	\$157,467,718
MU	1,521	\$54,457,756

Key: AIU= Adopt, Implement or Upgrade MU= Meaningful Use

2014 Goals – April Update

Federally Funded REC

Supporting adoption and achievement of Stage 1 Meaningful Use with a minimum of 3,724 priority providers across Michigan's primary care community.

- **3,724(+) Milestone 1:** Recruitment of Eligible Priority Primary Care Providers (PPCPs); 100% to goal
- **3,724(+) Milestone 2:** EHR Go-Live with PPCPs; 100% to goal
- **2,667 Milestone 3:** Stage 1 Meaningful Use Attestation with PPCPs; 70% to goal

MDCH Medicaid Specialists

Supporting specialists with high volumes of Medicaid patients in attaining Meaningful Use.

- **290 Milestone 1 Sign-Ups:** Recruitment of specialists (Non-Primary Care) who are eligible for participation in the Medicaid EHR Incentive Program (through MDCH)
- **Specialist Sign-Up breakdown:** Dentistry – 71%, Psychiatry - 16%, Optometry – 4%, Other – 9%
- **Program Goal:** Specialists successfully attest to 90 days of Meaningful Use (Stage One Year One)

M-CEITA Provider Metrics

Client data provides insight into EHR adoption and Meaningful Use landscape across Michigan Providers.

- 1 in 3 Michigan Physicians paid for Meaningful Use Stage 1 were Mceita Clients.
- To date, 69% of M-CEITA clients have achieved Stage 1 Year 1 in Meaningful Use. In 2013, 52% of those who achieved this goal were enrolled in the Medicare EHR Incentive Program and 48% were in the Medicaid Incentive Program.

Million Hearts Initiative

Expanding our focus to assist providers with future stages of MU, other quality process improvement and public health priorities with an emphasis on EHR-enabled improvements.

- A national initiative launched by HHS to prevent 1 million heart attacks and strokes by 2017 through provider engagement.
- M-CEITA supports Million Hearts as a key public health priority with an education tool for providers during the CQM selection and external promotion to adopt this initiative through our webinars, blogs and website.
- In 2014 M-CEITA will begin tracking client practices that have committed to using the Million Hearts related CQMs.
- On 4/16/2014 MCEITA will be hosting a Million Hearts webinar.

April 2014 Updates

- HB 5136
- Michiana QO application
- ADT follow up



Meaningful Use Discussion

M-CEITA





M-CEITA | MICHIGAN CENTER FOR
EFFECTIVE IT ADOPTION

Meaningful Use Stage 2

Overview, Opportunities and Barriers

Bruce Maki & Laura Rappleye

HIT Commission Meeting
April 17, 2014

Presentation Topics

1. MU Stage 2: Overview, Progress and Barriers
2. Audits and Payment Adjustments
3. The Challenge of Interoperability
4. Questions

The National EHR Incentive Program to date:

- ▲ 149,315 = Providers signed up with an REC
- ▲ 132,989 = REC providers live with an EHR
- ▲ 89,299 = REC providers demonstrating Meaningful Use
- ▲ \$20,621,344,041 = Total payments to all Eligible Providers
 - \$13,839,260,682 = Payments to Eligible Hospitals
 - \$6,782,083,359 = Payments to Eligible Professionals



Payments Made to Michigan Providers:

Medicaid	Providers Paid	Total Paid
AIU	3025	\$139,204,193
Meaningful Use	774	\$ 47,462,788

Source: <http://www.MichiganHealthIT.org> (as of 1/28/2014)

Medicare	Providers Paid	Total Paid
Meaningful Use	9,829	\$483,020,257

Source: <http://cms.gov/ehrincentiveprograms> (as of 1/31/2014)

EHR Incentive Program Statistics



EHR Incentive Program Trends

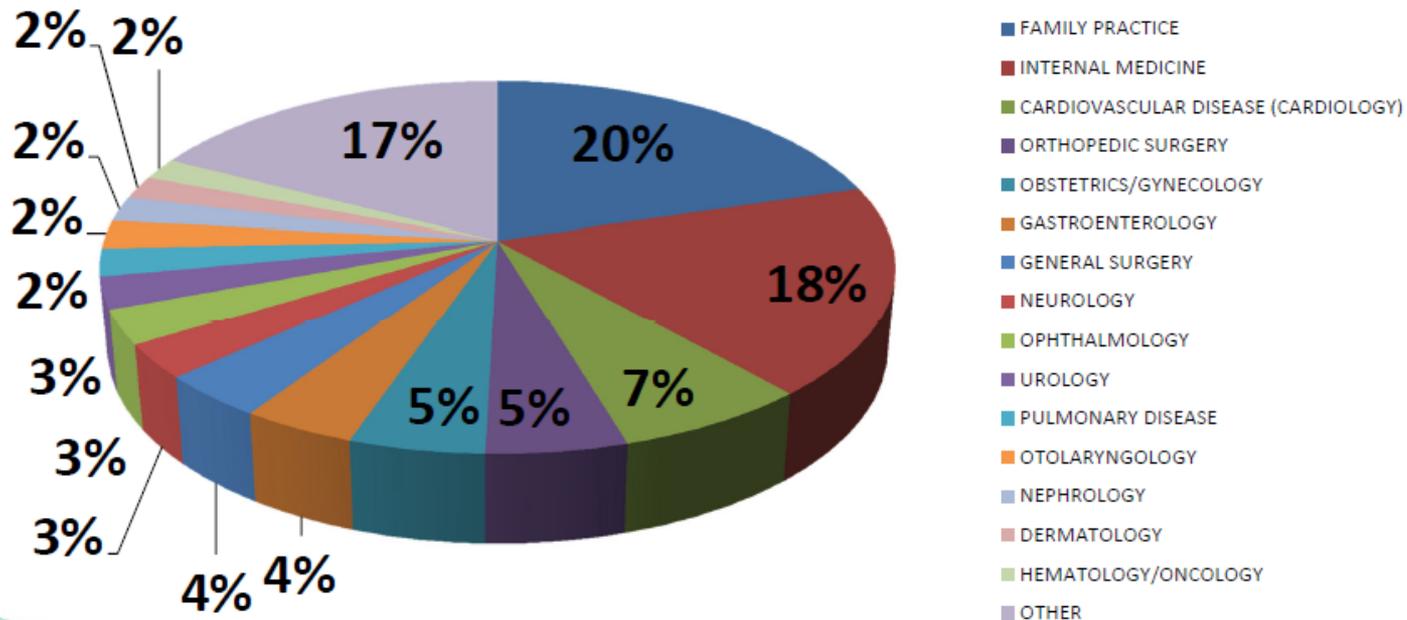
- Approximately **88% of all eligible hospitals** have received an EHR incentive payment for either MU or AIU
 - Nearly 9 out of 10 eligible hospitals have made a financial commitment to an EHR
- Approximately 60% or **3 out of every 5 Medicare EPs** are meaningful users of EHRs
- Approximately 78% or nearly **4 out of every 5 Medicaid EPs** of have received an EHR incentive payment
 - 20% of Medicaid EPs are meaningful users
- Almost 63% -- **3 out of every 5 Medicare and Medicaid EPs** have made a financial commitment to an EHR
- **Over 340,000 Medicare and Medicaid EPs** have received an EHR incentive payment

Who is achieving Meaningful Use?



Medicare EPs by Specialty – September 2013

61% of all Medicare EPs who are MUers are non-primary care



What does Stage 2 Mean to EPs?

- ▲ **New Criteria** – Starting in 2014, providers participating in the EHR Incentive Programs who have met Stage 1 for two or three years will need to meet meaningful use Stage 2 criteria.

- ▲ **Improving Patient Care** – Stage 2 includes new objectives to improve patient care through better clinical decision support, care coordination, and patient engagement.

- ▲ **Saving Money, Time, and Lives** – With Stage 2, EHRs should:
 - Save our health care system money
 - Save doctors and hospitals time
 - Save lives

Summary of Stage 2 Structure

Stage 2 retains the same basic structure as Stage 1 of meaningful use. Providers must report on 20 objectives in Stage 2.

The meaningful use measures are split into core and menu objectives. Eligible professionals must report on all core objectives, but can choose the menu measures that pertain to their practice.

Eligible professionals must now report on 17 core objectives and 3 out of a possible 6 menu objectives.



Do I need to upgrade my EHR?

CMS and the Office of the National Coordinator for Health Information Technology (ONC) have established standards and certification criteria for structured data that EHRs must use in order to successfully capture and calculate objectives for Stage 2 of meaningful use. These new standards and certification criteria will take effect in 2014.

Even if you already have a certified EHR, you will have to adopt or upgrade to the new certification in order to participate in the EHR Incentive Programs beginning in 2014.

EHR technology that is certified to the 2014 standards and certification criteria will allow providers to meet both Stage 1 and Stage 2 meaningful use requirements.

For more information about certified EHRs and the new 2014 standards and certification criteria, please visit ONC's new 2014 Certification Programs and Policy page: <http://www.healthit.gov/policy-researchers-implementers/certification-programs-policy>

Special Reporting Period in 2014

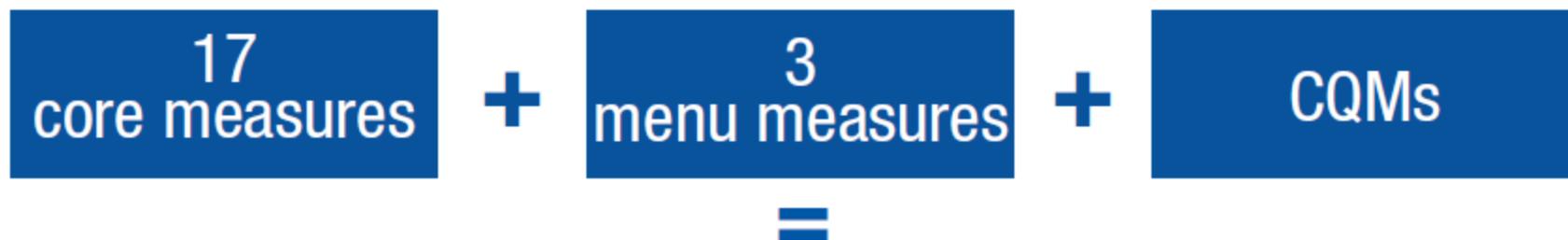
For 2014 Only

Because all providers must upgrade or adopt newly certified EHRs in 2014, all providers regardless of their stage of meaningful use are only required to demonstrate meaningful use for a **three-month (or 90-day)** EHR reporting period in 2014:

- ▲ Eligible Professionals (EPs) beyond their first year of Meaningful Use must select a three-month reporting period fixed to the quarter of the calendar year.
- ▲ EPs demonstrating Meaningful Use for the first time in 2014 may select any continuous 90 day reporting period (does not need to be affixed to a calendar quarter).
- ▲ Providers must attest to these reporting periods no later than February 28, 2015 at 11:59pm ET.

What are Stage 2 Objectives?

- ▲ Stage 2 is the second step of meaningful use for eligible professionals. After EPs have demonstrated meaningful use under Stage 1 requirements, they will have to demonstrate meaningful use under the Stage 2 requirements.
- ▲ For Stage 2 of meaningful use, EPs must meet the thresholds for the 17 core and 3 menu objectives, and report on Clinical Quality Measures (CQMs).



Stage 2 of meaningful use

Stage 2 Meaningful Use: 17 Core Objectives

1. Use computerized provider order entry (CPOE) for medication, laboratory and radiology orders	10. Incorporate clinical lab-test results into Certified EHR Technology
2. Generate and transmit permissible prescriptions electronically (eRx)	11. Generate lists of patients by specific conditions to use for quality improvement, reduction of disparities, research, or outreach
3. Record demographic information	12. Use clinically relevant information to identify patients who should receive reminders for preventive/follow-up care
4. Record and chart changes in vital signs	13. Use certified EHR technology to identify patient-specific education resources
5. Record smoking status for patients 13 years old or older	14. Perform medication reconciliation
6. Use clinical decision support to improve performance on high-priority health conditions	15. Provide summary of care record for each transition of care or referral
7. Provide patients the ability to view online, download and transmit their health information	16. Submit electronic data to immunization registries
8. Provide clinical summaries for patients for each office visit	17. Use secure electronic messaging to communicate with patients on relevant health information
9. Protect electronic health information created or maintained by Certified EHR Technology	

Stage 2 Meaningful Use: 6 Menu Objectives

1. Submit electronic syndromic surveillance data to public health agencies
2. Record electronic notes in patient records
3. Imaging results accessible through CEHRT
4. Record patient family health history
5. Report cancer cases to a public health central cancer registry
6. Report specific cases to a specialized registry

Important Note: While there are exclusions provided for some of these menu objectives, you cannot select a menu objective and claim the exclusion if there are other menu objectives that you could report on instead.

Clinical Quality Measures (CQMs)

Prior to 2014

EPs

Report 6 out of 44 CQMs

- 3 core or alt. core
- 3 menu

Eligible Hospitals and CAHs

Report 15 out of 15 CQMs



Beginning in 2014

EPs

Report 9 out of 64 CQMs

Selected CQMs must cover at least 3 of the 6 NQS domains

Recommended core CQMs:
9 for adult populations
9 for pediatric populations

Eligible Hospitals and CAHs

Report 16 out of 29 CQMs

Selected CQMs must cover at least 3 of the 6 NQS domains

▲ National Quality Strategy Domains

- Patient and Family Engagement
- Patient Safety
- Care Coordination
- Populations and Public Health
- Efficient Use of Healthcare Resources
- Clinical Processes/Effectiveness



Clinical Quality Measures (Con't)

- ▲ Prior to 2014, CQMs were a Core Objective (#10)
- ▲ 2014 and beyond: No longer a Core Objective but still a program requirement
- ▲ Medicare EHR Incentive Program participants beyond their first year of MU must electronically submit their CQMs as opposed to submitting by way of attestation.
- ▲ Medicaid EHR Incentive Program participants have the choice to submit CQMs electronically or by way of attestation in 2014. Electronic reporting of CQMs will be required in 2015.

Audits and Payment Adjustments



Medicare Payment Adjustments

- ▲ The HITECH Act stipulates that a Medicare payment adjustment applies to any Eligible Professional (EP), Eligible Hospital (EH) and Critical Access Hospital (CAH) if they are not a meaningful user
- ▲ Defined as **successful attestation to meaningful use** under either the Medicare or Medicaid EHR incentive program
- ▲ A provider receiving Medicaid payment Adopt, Implement or Upgrade (AIU) **does not** qualify as achieving meaningful use; would still be subject to payment adjustments
- ▲ If you are eligible to participate in both the Medicare and Medicaid EHR Incentive Programs, you **MUST** demonstrate meaningful use to avoid payment adjustments. You may demonstrate meaningful use under either Medicare or Medicaid.

Payment Adjustments (Medicare) Timeline

MU must be demonstrated according to a specific timeline to avoid payment adjustments

EP who demonstrates MU in 2011, 2012 or 2013						
Year MU must be Demonstrated	2013	2014	2015	2016	2017	2018
Payment Adjustment Year	2015	2016	2017	2018	2019	2020

MU must continue to be demonstrated every year to avoid payment adjustments in subsequent years

Avoiding the 2015 Payment Adjustments

Demonstrate meaningful use to CMS or the State by:

Meaningful EHR User in 2011 or 2012	Never been a Meaningful EHR User
End EHR reporting period by Dec 31, 2013	End EHR reporting period by Sept 30, 2014
Attest by March 31, 2014	Attest by Oct 1, 2014

– OR –

Apply to CMS for a hardship exception by:

July 1, 2014

Hardship Exceptions for Eligible Professionals

EPs can apply for hardship exceptions in the following categories:

1. Lack of Infrastructure

- The EP is located in an area without sufficient Internet access to comply with the Meaningful Use objectives requiring Internet connectivity, and faced insurmountable barriers to obtaining such Internet connectivity.

2. Unforeseen and/or Uncontrollable Circumstances

- The EP faced extreme and uncontrollable circumstances that prevented the EP from becoming a meaningful EHR user.

3. Lack of control over the availability of Certified EHR Technology

- The EP practices at multiple locations and is unable to control the availability of CEHRT at one such practice location or a combination of practice locations, and where the location or locations constitute more than 50 percent of patient encounters.

4. Lack of Face-to-Face Interaction

- The EP can demonstrate either a complete lack of face-to-face interactions and follow-up or that the cases of face-to-face interaction and follow-up are extremely rare and not part of normal scope of practice for that EP.

5. 2014 EHR Vendor Issues

- During the calendar year (2014) preceding the payment adjustment year (2015), the EP's EHR vendor was unable to obtain 2014 certification or the EP was unable to implement Meaningful Use due to 2014 EHR certification delays.

Incentive Payment Audits

- ❑ Any provider that receives an EHR incentive payment for either EHR Incentive Program may be subject to an audit
- ❑ CMS, and its contractor, Figliozi and Company, will perform audits on Medicare and dually-eligible (Medicare and Medicaid) providers who are participating in the EHR Incentive Programs
- ❑ States, and their contractor, will perform audits on Medicaid providers participating in the Medicaid EHR Incentive Program



Audit Strategy

The scope of the HITECH Audit Strategy includes:

A primary risk assessment strategy that helps identify and focus on high risk areas for Audit

A data audit logic strategy to identify variation in submissions as a means to qualify candidates for Audit.

A data validation approach for HITECH audit and help to identify the data sources useful for validation.

An alternate strategy for auditing data submitted by EP and EH against Meaningful Use criteria

Audit Timing

- ▲ Post-payment audits began in July 2012, and will take place during the course of the EHR Incentive Programs
- ▲ CMS began pre-payment audits in 2013, starting with attestations submitted during and after 2013
 - Pre-payment audits are in addition to the pre-payment edit checks that have been built into the EHR Incentive Programs' systems to detect inaccuracies in eligibility, reporting and payment
- ▲ Providers selected for pre- or post-payment audits will be required to submit supporting documentation to validate their submitted attestation data



Audit Documentation

- ▲ EPs, eligible hospitals and CAHs should retain all relevant supporting documentation – in either paper or electronic format – used to complete the Attestation Module as follows:
 - Documentation to support attestation data for meaningful use objectives and clinical quality measures should be retained for six years post-attestation
 - Documentation to support payment calculations (such as cost report data) should follow the current documentation retention processes



Medicare Audit Process Overview

1. Initial request letters sent to providers selected for an audit
2. Initial review process conducted using info provided in response to request letter
 - Additional info may be needed during or after initial review process
3. On-site review at provider's location may follow
 - A demonstration of EHR system may be required
4. Figliozi and Company will use secure communication process to assist provider in sending sensitive info
5. Questions pertaining to info requested should be directed to Figliozi and Company
6. If found ineligible for payment, provider's payment will be recouped/ will not be distributed

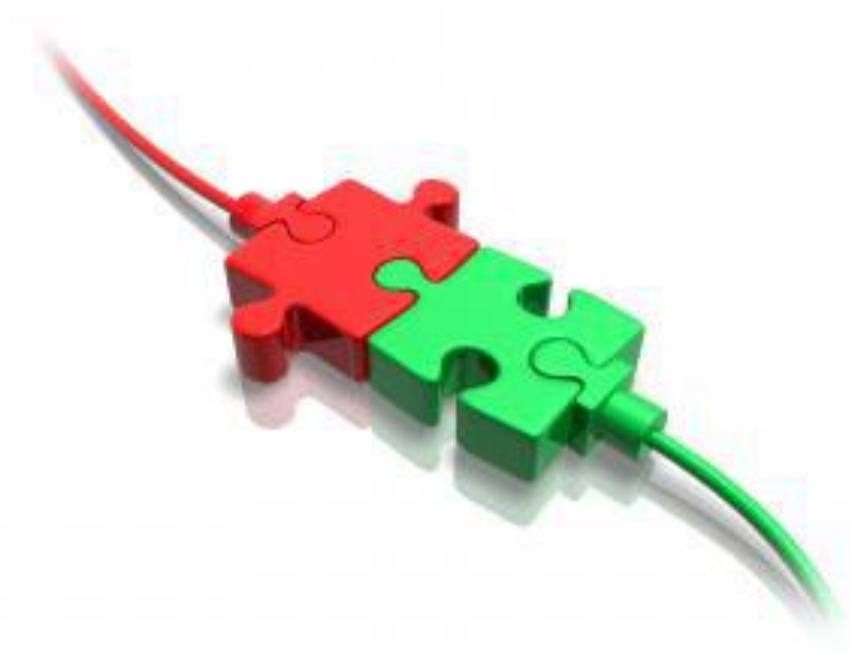


Most common audit issues:

- ▲ Drug-Drug and Drug-Allergy Checks
- ▲ Drug Formulary Check
- ▲ Verifying less than 100 Rx's (for claiming the exclusion)
- ▲ Clinical Decision Support Rule not enabled
- ▲ Exchange of key clinical information (no proof)
- ▲ Submission of electronic data to immunization registries (no proof)
- ▲ Protect electronic health information (SRA issues)
- ▲ Medicaid patient volume using Group Proxy



Interoperability: Challenges and Opportunities





Definition of Interoperability



- The Institute for Electrical and Electronics Engineering Computer Dictionary defines interoperability as
 - “the ability of two or more systems or components to exchange information and to use the information that has been exchanged.”
 - See IEEE Standard Computer Dictionary: A Compilation of IEEE Standard Computer Glossaries (New York, NY: 1990).
- That means that there are two parts to the definition of interoperability:
 - The ability of two or more systems to **exchange** information
 - The ability of those systems to **use** the information that has been exchanged





1. Interoperability Requirements in the 2014 Edition EHR Certification Criteria



Purpose	Interoperability Standards Requirements	Single Standard?	More interoperable than 2011?
Electronic prescribing	Standardized e-prescription format, with standardized medication codes	Yes	Yes
Identify Patient Education	Standardized ability for providers to request education resources from 3 rd party content providers	Yes	Yes
Transitions of care	<ul style="list-style-type: none"> Standardized summary care record with standardized clinical terminologies Uniform capability to transmit between systems 	Yes	Yes
Incorp./ Transmission of Lab Tests	<ul style="list-style-type: none"> Standardized interface requirement to receive and transmit lab data with standardized clinical terminologies 	Yes	Yes





2. Interoperability Requirements in the 2014 Edition EHR Certification Criteria



Purpose	Interoperability Standards Requirements	Single Standard?	More interoperable than 2011?
View, Download, Transmit to 3 rd party	<ul style="list-style-type: none"> Standardized summary care record with standardized clinical terminologies Uniform transmission capability for patients 	Yes	Yes
Clinical Summaries	Standardized summary care record with standardized clinical terminologies	Yes	Yes
Data Portability	Standardized summary care record with standardized clinical terminologies	Yes	Yes
Public Health reporting	<ul style="list-style-type: none"> Standardized transmission to immunization registries Standardized transmission of reportable lab results Standardized transmission of syndromic surveillance data Standardized transmission for cancer case reporting 	Yes	Yes



Meeting the Measures without the “E” in Interoperability

Objective	Attesting “YES” to the Measure
CPOE for Med, Lab and Rad Orders	<ul style="list-style-type: none"> • Must meet the numerator/denominator thresholds • Orders created must be recorded using CPOE • Electronic transmittal of the order is not a requirement (eRx measure requires transmission)
Patient-Specific Education Resources and Clinical Decision Support	<ul style="list-style-type: none"> • Must meet the numerator/denominator thresholds • Number of patients provided patient –specific education resources • Not required to use Context-Aware Retrieval Application (Infobutton) to retrieve from 3rd party content providers
Incorporate Lab Results	<ul style="list-style-type: none"> • Must meet the numerator/denominator thresholds • Structured data does not need to be electronically exchanged in order to qualify for the measure of this objective. • Not limited to only counting structured data received via electronic exchange, but may count in the numerator all structured data entered through manual entry through typing, option selecting, scanning, or other means

Meeting the Measures without the “E” in Interoperability (Cont’d)

Objective	Attesting “YES” to the Measure
Clinical Summaries to Patients	<ul style="list-style-type: none"> • Must meet the numerator/denominator thresholds • The clinical summary can be provided through a PHR, patient portal on the web site, secure e-mail, electronic media such as CD or USB fob, or printed copy
Imaging Results	<ul style="list-style-type: none"> • Must meet the numerator/denominator thresholds • A link to where the image and accompanying information is stored is available in CEHRT. • Images and imaging results that are scanned into the CEHRT may be counted in the numerator of this measure

Public Health Reporting: Ongoing Submission

Providers can attest **YES** to meeting the measure, if one of four scenarios are met:

Scenario 1

- Submitting the required public health data prior to Stage 2 using a 2014 ONC certified EHR **AND**
- Continues to submit during the EPs reporting period

Scenario 2

- Registered intent within 60 days of the EPs reporting period **AND**
- Achieved ongoing submission during the Stage 2 reporting period

Scenario 3

- Registered intent within 60 days of the EPs reporting period **AND**
- Engaged in the required testing and validation process leading to ongoing submission

Scenario 4

- Registered intent within 60 days of the EPs reporting period **AND**
- Awaiting an invitation to engage in the required testing and validation process

Public Health Reporting and Transport

All Public Health Reporting will be transported through MiHIN Qualified Organizations

Sample of Survey Questions	QO A	QO B	QO C
Do you have interfaces with CEHRTs to transport immunizations to MCIR?	Yes	Yes	Yes, but no longer available
Is there a fee for interface development between EHR and QO?	No	Yes, \$1000	No longer available

Meeting the Transition of Care (TOC) Measures

Measure 1

- The EP can send an electronic or paper copy of the summary care record directly to the next provider or can provide it to the patient to deliver to the next provider

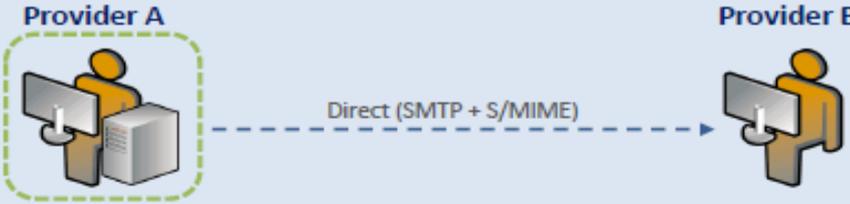
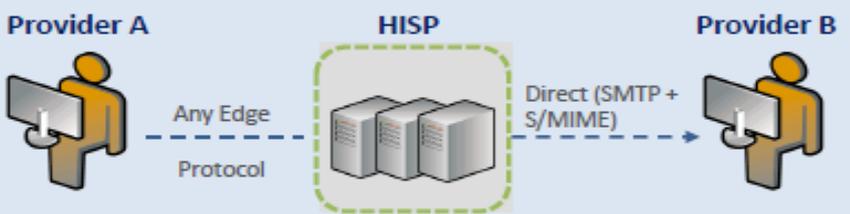
Measure 2

- Requires a provider electronically transmit a summary care record for more than 10% of transitions of care and referrals using CEHRT or eHealth Exchange participant

Measure 3

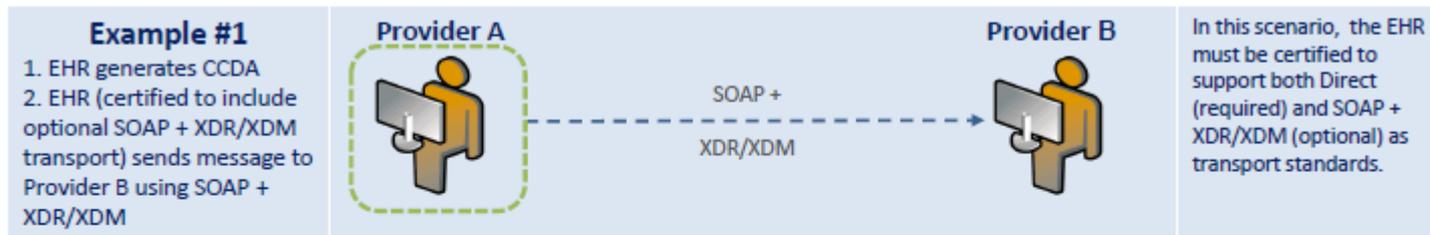
- Requires at least one summary care record electronically transmitted to recipient with different EHR vendor **OR**
- Submit one to CMS

TOC Measure 2 and 3 Direct Transport Options

<p>Scenario #1</p> <ol style="list-style-type: none"> 1. EHR generates CCDA 2. EHR performs as STA and sends Direct msg <p>Complete EHR or EHR Module certification issued.</p>		<p>STA/HISP function integrated into EHRs; no separate certification testing for HISP.</p>
<p>Scenario #2</p> <ol style="list-style-type: none"> 1. EHR sends "data" to HISP 2. HISP generates CCDA 3. HISP performs as STA and sends Direct msg <p>EHR Module certification issued.</p>		<p>HISP certified independently as EHR Module.</p>
<p>Scenario #3</p> <ol style="list-style-type: none"> 1. EHR generates CCDA 2. EHR sends CCDA to HISP 3. HISP performs as STA and sends Direct msg <p>Complete EHR or EHR Module certification issued.</p>		<p>HISP certified as "relied upon software" with the EHR. Certification given to the pair, not EHR and HISP separately.</p>

--- CEHRT

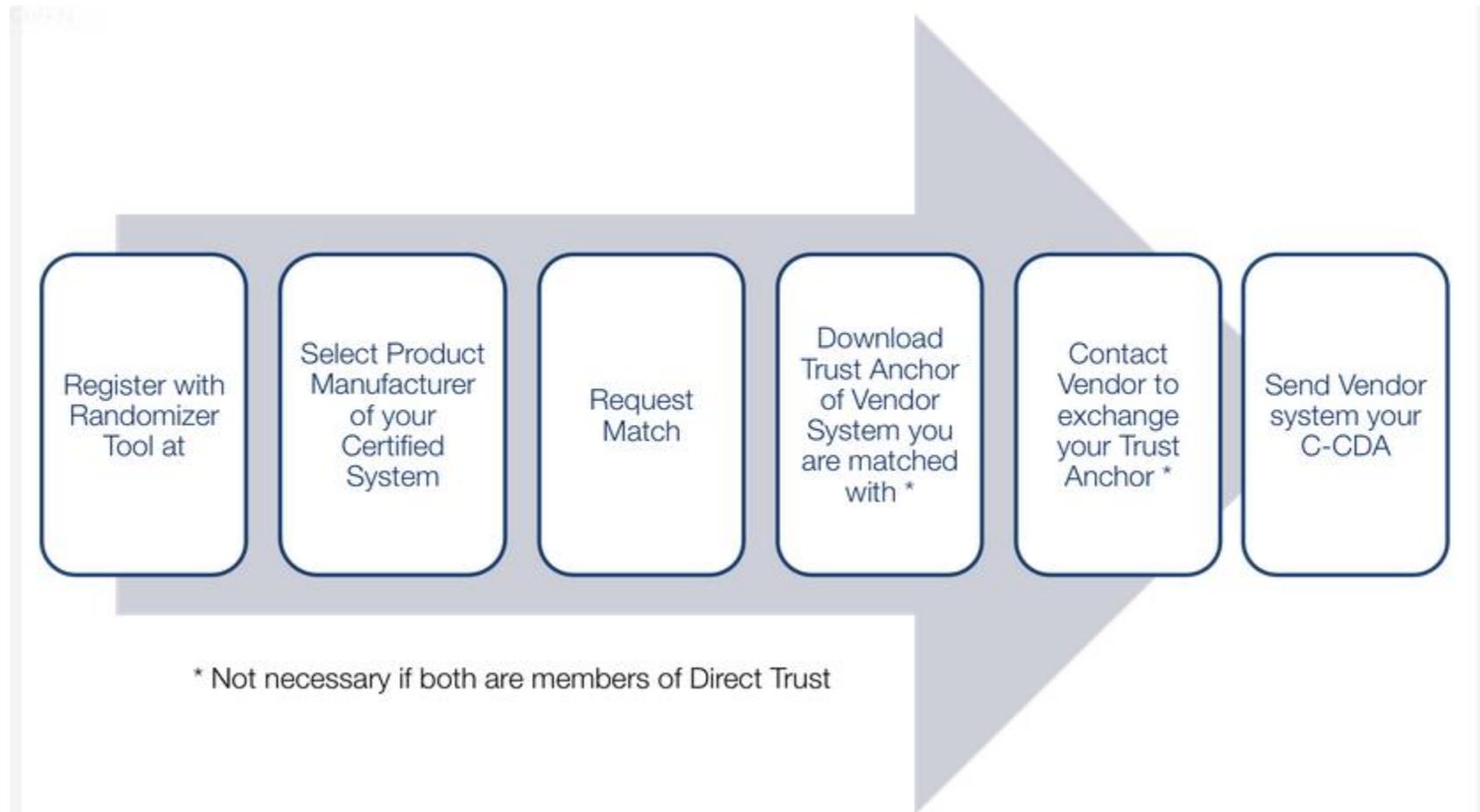
TOC Measure 2 and 3 Transport SOAP Option



--- CEHRT

Note: This is one example of how a provider may use EHR technology that has been certified to include optional transport standards. The CEHRT could support a different optional transmission mechanism (e.g., Direct + XDR/XDM). Also, as with the required Direct transport, the CEHRT has architectural flexibility to use relied upon software in their solution, seek modular certification, etc.

TOC Measure 3 Cross-Vendor Exchange Option



Feb. 4-5 2014 TOC Connect-a-thon Findings

- ▲ Nearly all the EHR vendors and HISPs were able to successfully exchange CCDA documents via Direct
- ▲ Many EHR vendors are not allowing end users to use Direct as a general transport tool, but are instead building it into their systems as a “care summary only” transport. This includes an inability to handle other file types in payloads.
- ▲ Many EHR vendors do not provide good visibility into transaction status for clinicians (e.g., no notification of failure to receive an MDN).
 - Meaningful Use adopts objectives where CEHRT needs to account for the successful delivery of transition of care transactions from the source to the destination

Questions to Health Information Exchanges

- ▲ How are you supporting providers meet the TOC transport requirements?
 - Allowing EHRs to connect using SOAP + XDR/XDM (HISPs do not need modular certification under this model to support MUS2)
 - Partnering with an EHR vendor and get certified as pre-coordinated bundle
 - Getting a modular certification for CCDA translation and Direct
 - Becoming an eHealth Exchange participant
- ▲ Which Stage 2 “interoperability” objectives do you support?
 - What cost is associated?
- ▲ Where do we direct providers for more information?

So, how do we help providers get on the bus?





Questions?

www.mceita.org

Bruce Maki
bruce.maki@altarum.org
734-302-4474

Laura Rappleye
laura.rappleye@altarum.org
734-302-4759

Transition of Care Acronyms

- ▲ CCDA (Consolidated Clinical Document Architecture): an XML-based markup standard intended to specify the encoding, structure, and semantics of clinical documents for exchange.
- ▲ HISP (Health Information Service Provider): is a role in a Direct message exchange that provides edge protocols, message formatting, security, and routing according to the Direct project specification. A HISP also provides truststore management tools and services for Direct users. The HISP role may be played by providers, payers, EHR vendors, PHR vendors, health information exchanges, and third-party entities.
- ▲ MIME (Multipurpose Internet Mail Extensions): an Internet standard that extends email to support other content types, including non-text attachments.
- ▲ S/MIME (Secure/Multipurpose Internet Mail Extensions): an Internet standard for public key encryption and signing of MIME data.
- ▲ SOAP (Simple Object Access Protocol): a protocol specification for exchanging structured information in the implementation of web services in computer networks.
- ▲ STA (Security/Trust Agents): organizations responsible for providing the services necessary to exchange using Direct, such as, HISPs.
- ▲ XDR (Cross-Enterprise Document Reliable Interchange (XDR) / XDM (Cross-Enterprise Document Media Interchange): IHE standard for supporting XML-based detailed metadata along with SMTP- or SOAP-based transport options.
- ▲ XML (eXtensible Markup Language): defines a set of rules for encoding documents in a format that is both human-readable and machine-readable.

HITC Next Steps

- Co-Chair Nominations
- Summer Schedule



Public Comment



Adjourn

