

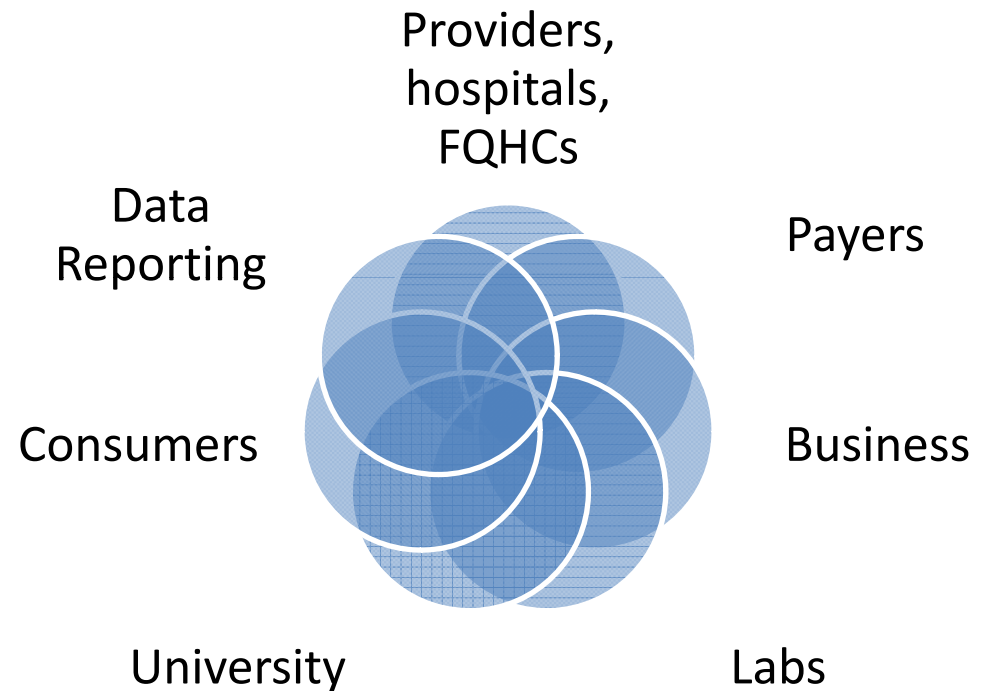


# Hawai'i Health Information Exchange

# What Is Hawai'i HIE?



- 21 member BoD
- Extensive HIT experience
- Broad community support
- A non-profit 501(c)(3)
- Became the State Designated Entity in Sept. 2009



# Mission

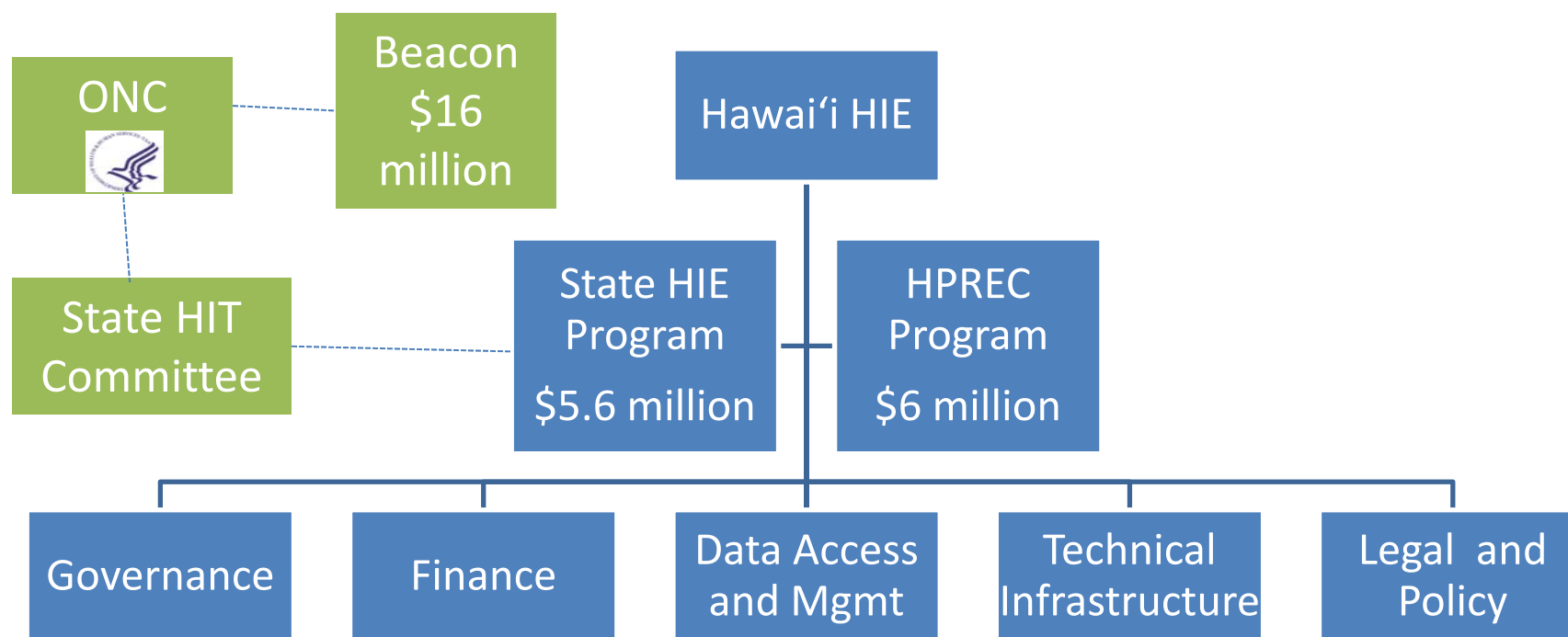
- To facilitate the exchange of health information that enables high quality and affordable health care statewide
- Core Values & Guiding Principles:
  - Inclusivity
  - Quality
  - Transparency
  - Privacy
  - Sustainability

# Our Grants



- State HIE Program
  - Develop and implement a Strategic and Operational Plan to ensure progress within the state of Hawai'i toward adoption of HIE
- Regional Extension Center (REC) Program
  - Through the Hawai'i Pacific REC services, offer physicians support in selecting and implementing an electronic health record (EHR) system and in achieving Meaningful Use to become eligible for Medicare and Medicaid EHR Incentive Payments.

# Programmatic Organizational Chart



# State HIE Project Timeline



- Sept. 2009 – became the SDE
- Sept. 2009 – submitted grant application
- Feb. 2010 – awarded
- Mar. 2010 – planning process approved
- Mar.-July 2010 – develop draft plan
- August 17<sup>th</sup> – Board approved Plan
- August 30<sup>th</sup> – State Coordinating Committee for HIT approved Plan
- **August 30<sup>th</sup> – ONC received Plan from HHIE**
- Sept. 10<sup>th</sup> – HHIE reviewed initial feedback from ONC
  - ONC project officer review (complete)
  - ONC review (9/17)
  - ONC provides written feedback to HHIE (10/8)
  - HHIE submits written feedback to ONC (10/22)
- Oct. 22<sup>nd</sup> – ONC-HHIE approval phase of plan
- November 2010 – begin implementation

Over the next 4 years, we will oversee the development of a statewide HIE to improve the quality of health in Hawai'i.

# Why Develop New HIT Programs?

- Furnish tools to begin a major transformation in American health care
- Provide best opportunity for each patient to receive optimal care through nationwide health information exchange
- Address the most pressing obstacles to adoption and meaningful use of electronic health records (EHR) through programs and regulations

# Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs and Meaningful Use (MU)

# Meaningful Use in Hawai'i



Sand



Meaningful Use of Sand

# What makes someone a meaningful user of EHRs?

- ARRA specifies the following 3 criteria for being a meaningful user of (EHRs):
  - Use of certified EHR technology in a meaningful manner (ex: E-prescribing)
  - Use of certified EHR technology to submit clinical quality reporting and other measures
  - Use of certified EHR technology for electronic exchange of health information to improve quality of health care

# Qualifying for Incentive Payments and Reporting Requirements

# Types of Eligible Professionals

## Medicare

- Doctor of medicine or osteopathy
- Doctor of oral surgery or dental medicine
- Doctor of podiatric medicine
- Doctor of optometry
- Chiropractor

NOTE: Hospital-based EPs are not eligible to participate. An EP is considered to be hospital-based if the EP furnishes 90% of his/her services in a hospital inpatient or emergency room setting.

## Medicaid

- Physicians
- Dentists
- Certified nurse-midwives
- Nurse practitioners
- Physician assistants practicing in a Federally Qualified Health Center (FQHC) or a Rural Health Clinic (RHC) led by a physician assistant

NOTE: Hospital-based EPs are not eligible unless that Medicaid EP practices predominately in an FQHC or RHC

# EPs Qualifying for Incentive Payments

## **Eligible Professionals (EPs) must:**

- Meet 15 Meaningful Use core requirements + 5 menu requirements from a list of 10 set objectives
- Report on 3 required core Clinical Quality Measures (CQMs), and if the denominator of 1 or more of the required core measures is 0, then EPs are required to report results for up to 3 alternate core measures.
- Select 3 additional CQMs from a set of 38 CQMs. It is acceptable to have a '0' denominator provided the EP does not have an applicable population.

# Meaningful Use: Applicability of Objectives and Measures

- Some MU objectives are not applicable to every provider's clinical practice, thus they would not have any eligible patients or actions for the measure denominator.
- In these cases, the EP would be excluded from having to meet that measure
  - Ex: Dentists who do not perform immunizations; Chiropractors do not e-prescribe

# MEANINGFUL USE – STAGE 1 CORE SET

Health Outcomes Policy Priority	Stage 1 Objective	Stage 1 Measure
Improving quality, safety, efficiency, and reducing health disparities	Use CPOE for medication orders directly entered by any licensed healthcare professional who can enter orders into the medical record per state, local, and professional guidelines	More than 30% of unique patients with at least one medication in their medication list seen by the EP or admitted to the eligible hospital or CAH have at least one medication entered using CPOE
	Implement drug-drug and drug-allergy interaction checks	The EP/eligible hospital/CAH has enabled this functionality for the entire EHR reporting period
	EP Only: Generate and transmit permissible prescriptions electronically (eRx)	More than 40% of all permissible prescriptions written by the EP are transmitted electronically using certified EHR technology
	Record demographics: preferred language, gender, race, ethnicity, date of birth, and date and preliminary cause of death in the event of mortality in the eligible hospital or CAH	More than 50% of all unique patients seen by the EP or admitted to the eligible hospital or CAH have demographics as recorded structured data
	Maintain up-to-date problem list of current and active diagnoses	More than 80% of all unique patients seen by the EP or admitted to the eligible hospital or CAH have at least one entry or an indication that no problems are known for the patient recorded as structured data

# MEANINGFUL USE – STAGE 1 CORE SET

(CONT'D)

Health Outcomes Policy Priority	Stage 1 Objective	Stage 1 Measure
Improving quality, safety, efficiency, and reducing health disparities	Maintain active medication list	More than 80% of all unique patients seen by the EP or admitted to the eligible hospital or CAH have at least one entry (or an indication that the patient is not currently prescribed any medication) recorded as structured data
	Maintain active medication allergy list	More than 80% of all unique patients seen by the EP or admitted to the eligible hospital or CAH have at least one entry (or an indication that the patient has no known medication allergies) recorded as structured data
	Record and chart vital signs: height, weight, blood pressure, calculate and display BMI, plot and display growth charts for children 2-20 years, including BMI	For more than 50% of all unique patients age 2 and over seen by the EP or admitted to the eligible hospital or CAH, height, weight, and blood pressure are recorded as structured data
	Record smoking status for patients 13 years old or older	More than 50% of all unique patients 13 years or older seen by the EP or admitted to the eligible hospital or CAH have smoking status recorded as structured data
	Implement one clinical decision support rule and the ability to track compliance with the rule	Implement one clinical decision support rule
	Report clinical quality measures to CMS or the States	For 2011, provide aggregate numerator, denominator, and exclusions through attestation; For 2012, electronically submit clinical quality measures

# MEANINGFUL USE – STAGE 1 CORE SET

(CONT'D)

Health Outcomes Policy Priority	Stage 1 Objective	Stage 1 Measure
Engage patients and families in their healthcare	Provide patients with an electronic copy of their health information (including diagnostic test results, problem list, medication lists, medication allergies, discharge summary, procedures), upon request	More than 50% of all unique patients of the EP, eligible hospital or CAH who request an electronic copy of their health information are provided it within 3 business days
	Hospitals Only: Provide patients with an electronic copy of their discharge instructions at time of discharge, upon request	More than 50% of all patients who are discharged from an eligible hospital or CAH who request an electronic copy of their discharge instructions are provided it
	EPs Only: Provide clinical summaries for each office visit	Clinical summaries provided to patients for more than 50% of all office visits within 3 business days
Improve care coordination	Capability to exchange key clinical information (ex: problem list, medication list, medication allergies, diagnostic test results), among providers of care and patient authorized entities electronically	Performed at least one test of the certified EHR technology's capacity to electronically exchange key clinical information
Ensure adequate privacy and security protections for personal health information	Protect electronic health information created or maintained by certified EHR technology through the implementation of appropriate technical capabilities	Conduct or review a security risk analysis per 45 CFR 164.308(a)(1) and implement updates as necessary and correct identified security deficiencies as part of the EP's, eligible hospital's or CAH's risk management process

# MEANINGFUL USE – STAGE 1 MENU SET

Health Outcomes Policy Priority	Stage 1 Objective	Stage 1 Measure
Improving quality, safety, efficiency, and reducing health disparities	Implement drug-formulary checks	The EP/eligible hospital/CAH has enabled this functionality and has access to at least one internal or external drug formulary for the entire EHR reporting period
	Hospitals Only: Record advance directives for patients 65 years old or older	More than 50% of all unique patients 65 years old or older admitted to the eligible hospital or CAH have an indication of an advance directive status recorded
	Incorporate clinical lab-test results into certified EHR technology as structured data	More than 40% of all clinical lab test results ordered by the EP, or an authorized provider of the eligible hospital or CAH, for patients admitted during the EHR reporting period whose results are either in a positive/negative or numerical format are incorporated in certified EHR technology 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 report listing patients of the EP, eligible hospital or CAH with a specific condition
	EPs Only: Send reminders to patients per patient preference for preventive/follow-up care	More than 20% of all unique patients 65 years or older or 5 years old or younger were sent an appropriate reminder during the EHR reporting period

# MEANINGFUL USE – STAGE 1 MENU SET

(CONT'D)

Health Outcomes Policy Priority	Stage 1 Objective	Stage 1 Measure
Engage patients and families in their health care	EPs Only: Provide patients with timely electronic access to their health information (including lab results, problem list, medication lists, medication allergies) within 4 business days of the information being available to the EP	More than 10% of all unique patients seen by the EP are provided timely (available to the patient within 4 business days of being updated in the certified EHR technology) electronic access to their health information subject to the EP's discretion to withhold certain information
	Use certified EHR technology to identify patient-specific education resources and provide those resources to the patient, if appropriate	More than 10% of all unique patients seen by the EP or admitted to the eligible hospital or CAH are provided patient-specific education resources
Improve care coordination	The EP, eligible hospital or CAH who receives a patient from another setting of care or provider of care or believes an encounter is relevant should perform medication reconciliation	The EP, eligible hospital or CAH performs medication reconciliation for more than 50% of transitions of care in which the patient is transitioned into the care of the EP or admitted to the eligible hospital or CAH
	The EP, eligible hospital or CAH who receives a patient from another setting of care or provider of care or refers their patient to another provider of care should provide a summary of care record for each transition of care or referral	The EP, eligible hospital or CAH who transitions or refers their patient to another setting of care or provider of care provides a summary of care record for more than 50% of transitions of care and referrals

# MEANINGFUL USE – STAGE 1 MENU SET

(CONT'D)

Health Outcomes Policy Priority	Stage 1 Objective	Stage 1 Measure
<p>Improve population and public health<sup>1</sup></p>	<p>Capability to submit electronic data to immunization registries or Immunization Information Systems and actual submission in accordance with applicable law and practice</p>	<p>Performed at least one test of the certified EHR technology's capacity to submit electronic data to immunization registries and follow-up submission if the test is successful (unless none of the immunization registries to which the EP, eligible hospital or CAH submits such information have the capacity to receive such information electronically)</p>
	<p>Hospitals Only: Capability to submit electronic data on reportable (as required by state or local law) lab results to public health agencies and actual submission in accordance with applicable law and practice</p>	<p>Performed at least one test of certified EHR technology's capacity to provide submission of reportable lab results to public health agencies and follow-up submission if the test is successful (unless none of the public health agencies to which the EP, eligible hospital or CAH submits such information have the capacity to receive such information electronically)</p>
	<p>Capability to submit electronic syndromic surveillance data to public health agencies and actual submission in accordance with applicable law and practice</p>	<p>Performed at least one test of certified EHR technology's capacity to provide electronic syndromic surveillance data to public health agencies and follow-up submission if the test is successful (unless none of the public health agencies to which the EP, eligible hospital or CAH submits such information have the capacity to receive such information electronically)</p>

<sup>1</sup>Unless an EP, eligible hospital or CAH has an exception for all of these objectives and measures they must complete at least one as part of their demonstration of the menu set in order to be a meaningful EHR user.

# Clinical Quality Measures (CQM) Overview

- 2011 – EPs seeking to demonstrate Meaningful Use are required to submit aggregate CQM numerator, denominator, and exclusion data to CMS or the States by attestation
- 2012 – EPs seeking to demonstrate Meaningful Use are required to electronically submit aggregate CQM numerator, denominator, and exclusion data to CMS or the States

# CQM: Eligible Professionals

- Core, Alternate Core, and Additional CQM sets for EPs
  - EPs must report on 3 required core CQM, and if the denominator of 1 or more of the required core measures is 0, then EPs are required to report results for up to 3 alternate core measures
  - EPs also must select 3 additional CQM from a set of 38 CQM (other than the core/alternate core measures)
  - In sum, EPs must report on 6 total measures: 3 required core measures (substituting alternate core measures where necessary) and 3 additional measures

# Clinical Quality Measures: Core Set

- Hypertension: Blood Pressure Measurement
- Preventative Care and Screening Measure Pair: a) Tobacco Use Assessment, b) Tobacco Cessation Intervention
- Adult Weight Screening and Follow-up

# Clinical Quality Measures: Alternate Core Set

- Weight Assessment and Counseling for Children and Adolescents
- Preventive Care and Screening: Influenza Immunization for Patients 50 Years Old or Older
- Childhood Immunization Status

# Clinical Quality Measures

## **Additional Set CQM–EPs must complete 3 of 38**

1. Diabetes: Hemoglobin A1c Poor Control
2. Diabetes: Low Density Lipoprotein (LDL) Management and Control
3. Diabetes: Blood Pressure Management
4. Heart Failure (HF): Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction (LVSD)
5. Coronary Artery Disease (CAD): Beta-Blocker Therapy for CAD Patients with Prior Myocardial Infarction (MI)
6. Pneumonia Vaccination Status for Older Adults
7. Breast Cancer Screening
8. Colorectal Cancer Screening
9. Coronary Artery Disease (CAD): Oral Antiplatelet Therapy Prescribed for Patients with CAD
10. Heart Failure (HF): Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD)

# Clinical Quality Measures

11. Anti-depressant medication management: (a) Effective Acute Phase Treatment, (b) Effective Continuation Phase Treatment
12. Primary Open Angle Glaucoma (POAG): Optic Nerve Evaluation
13. Diabetic Retinopathy: Documentation of Presence or Absence of Macular Edema and Level of Severity of Retinopathy
14. Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care
15. Asthma Pharmacologic Therapy
16. Asthma Assessment
17. Appropriate Testing for Children with Pharyngitis
18. Oncology Breast Cancer: Hormonal Therapy for Stage IC-III C Estrogen Receptor/Progesterone Receptor (ER/PR) Positive Breast Cancer
19. Oncology Colon Cancer: Chemotherapy for Stage III Colon Cancer Patients
20. Prostate Cancer: Avoidance of Overuse of Bone Scan for Staging Low Risk Prostate Cancer Patients
21. Smoking and Tobacco Use Cessation, Medical Assistance: a) Advising Smokers and Tobacco Users to Quit, b) Discussing Smoking and Tobacco Use Cessation Medications, c) Discussing Smoking and Tobacco Use Cessation Strategies

# Clinical Quality Measures

22. Diabetes: Eye Exam
23. Diabetes: Urine Screening
24. Diabetes: Foot Exam
25. Coronary Artery Disease (CAD): Drug Therapy for Lowering LDL-Cholesterol
26. Heart Failure (HF): Warfarin Therapy Patients with Atrial Fibrillation
27. Ischemic Vascular Disease (IVD): Blood Pressure Management
28. Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antithrombotic
29. Initiation and Engagement of Alcohol and Other Drug Dependence Treatment: a) Initiation, b) Engagement
30. Prenatal Care: Screening for Human Immunodeficiency Virus (HIV)
31. Prenatal Care: Anti-D Immune Globulin
32. Controlling High Blood Pressure
33. Cervical Cancer Screening
34. Chlamydia Screening for Women
35. Use of Appropriate Medications for Asthma
36. Low Back Pain: Use of Imaging Studies
37. Ischemic Vascular Disease (IVD): Complete Lipid Panel and LDL Control
38. Diabetes: Hemoglobin A1c Control (<8.0%)

# What is the reporting period for EPs participating in the EHR incentive program?

“For demonstrating MU through both the Medicare and Medicaid EHR Incentive Programs, the EHR reporting period for an EP’s first year is any continuous 90-day period within the calendar year. In subsequent years, the EHR reporting period for EPs is the entire calendar year. Under the Medicaid program, there is also an incentive for the adoption, implementation, or upgrade of certified EHR technology, which does not have a reporting period.”

[https://questions.cms.hhs.gov/app/answers/detail/a\\_id/9961](https://questions.cms.hhs.gov/app/answers/detail/a_id/9961)

# States' Flexibility to Revise Meaningful Use

- States can seek CMS prior approval to require 4 MU objectives be core for their Medicaid providers:
  - Generate lists of patients by specific conditions for quality improvement, reduction of disparities, research or outreach (can specify particular conditions)
  - Reporting to immunization registries, reportable lab results and syndromic surveillance (can specify for their providers how to test the data submission and to which specific destination)

# Medicare and Medicaid EHR Incentive Programs for Eligible Professionals

# What Eligible Professionals Need to Participate in the EHR Incentive Payment Program

- Certified EHR Technology
  - You must adopt, implement, upgrade, or meaningfully use certified EHR technology before receiving incentive payment
- NPI, PECOS, and NPPES

# Medicare Incentive Payment Program Options

Fee-for-Service (FFS)  
Medicare Advantage (MA)

# When Can EPs Receive FFS Medicare Payments?

- Calendar year (CY) from 2011 to 2014: EPs can begin receiving payments.
- EPs may receive payment for up to 5 years.
- After 2014: EPs do not qualify for initial payments.
- Starting in 2015, an EP who does not successfully demonstrate meaningful use **will be subject to reduced physician fee schedule payments.**
- Payments will be made on a rolling basis after CMS has ascertained that the EP met MU for the reporting period and the EP has met the max allowable charges threshold.
- EPs who demonstrate MU may be eligible for an incentive payment amount, subject to an annual limit, equal to 75% of the EP's Medicare allowed charges submitted no later than two months after the end of the CY.

# Maximum FFS Medicare Incentive Payments by Calendar Year for EPs

Calendar Year	Incentive Payments Based on the First CY in Which an EP Participates in the Program			
	2011	2012	2013	2014
2011	\$18,000			
2012	\$12,000	\$18,000		
2013	\$8,000	\$12,000	\$15,000	
2014	\$4,000	\$8,000	\$12,000	\$12,000
2015	\$2,000	\$4,000	\$8,000	\$8,000
2016		\$2,000	\$4,000	\$4,000
<b>TOTAL</b>	<b>\$44,000</b>	<b>\$44,000</b>	<b>\$39,000</b>	<b>\$24,000</b>

# Additional Medicare Payments for Health Professional Shortage Areas (HPSA)

- Payment limit may be increased by 10% each year for EPs who predominantly furnish more than 50% of services in a HPSA
- HPSA bonus is determined by the frequency of services provided over a one-year period from January 1 to December 31 rather than allowed charges

# Maximum Medicare Incentive Payments by Calendar Year for EPs Who Qualify for a HPSA Bonus

Calendar Year	Incentive Payments Based on the First CY in Which an EP Who Qualifies for a HPSA Bonus Payment Participates in the Program			
	2011	2012	2013	2014
2011	\$19,800			
2012	\$13,200	\$19,800		
2013	\$8,800	\$13,200	\$16,500	
2014	\$4,400	\$8,800	\$13,200	\$13,200
2015	\$2,200	\$4,400	\$8,800	\$8,800
2016		\$2,200	\$4,400	\$4,400
<b>TOTAL</b>	<b>\$48,400</b> (\$4,400 increase)	<b>\$48,400</b> (\$4,400 increase)	<b>\$42,900</b> (\$3,900 increase)	<b>\$26,400</b> (\$2,400 increase)

# Medicare Payment Adjustments for EPs

- Beginning in 2015, if an EP does not demonstrate MU, the EP's Medicare physician fee schedule amount for covered professional services will be adjusted.\*
  - 2015: 99%
  - 2016: 98%
  - 2017 and each subsequent year: 97%

NOTE: If for 2018 and subsequent years less than 75% of EPs are Meaningful Users, then the payment adjustment will change by 1% each year until reaching 95%.

\*Certain EPs could be exempt from the payment adjustment if they meet the description of a hardship exception.

# Medicare Advantage (MA) Payments for EPs

- For an EP to be considered for MA payments, the EP must either:
  - Furnish, on average, at least 20 hours/week of patient-care services and be employed by the qualifying MAO

Or

- Be employed by, or be a partner of, an entity that, through contract with the qualifying MAO, furnished at least 80% of the entity's Medicare patient care services enrollees

# Maximum **MA** **EP** Incentive Payments by Calendar Year

Calendar Year	Incentive Payments Based on the First CY the MAO Receives an Incentive Payment			
	2011	2012	2013	2014
2011	\$18,000			
2012	\$12,000	\$18,000		
2013	\$8,000	\$12,000	\$15,000	
2014	\$4,000	\$8,000	\$12,000	\$12,000
2015	\$2,000	\$4,000	\$8,000	\$8,000
2016		\$2,000	\$4,000	\$4,000
<b>TOTAL</b>	<b>\$44,000</b>	<b>\$44,000</b>	<b>\$39,000</b>	<b>\$24,000</b>

# FFS and MA

## Medicare Duplicate Payments

- Duplicate payments may not be made for EPs eligible for both the FFS and the MA incentive payments.
- If an EP is eligible for both, the Medicare FFS payment will be made first, but only if it is for the maximum amount due for that payment year.
- If an EP did not receive the maximum FFS payment, then the MAO will receive the incentive payment solely through the MA incentive program.

# Medicaid Incentive Payment Program

# Medicaid Patient Volume Requirements for EPs

- To be eligible, an EP must either:
  - Meet certain Medicaid patient volume thresholdsOr
  - Practice predominantly in a FQHC or RHC where 30% of the patient volume is derived from needy individuals. Needy individuals are meet any of the following three criteria:
    - They are receiving medical assistance from Medicaid or the Children's Health Insurance Program
    - They are furnished uncompensated care by the provider
    - They are furnished services at either no cost or reduced cost based on the individual's ability to pay

# Medicaid Patient Volume Thresholds per Provider Type

Entity	Minimum Medicaid Patient Volume Threshold (percent)*	Or the Medicaid EP practices predominantly in a FQHC or RHC with a 30% needy individual patient volume threshold
Physician	30	
Pediatrician	20	
Dentist	30	
Certified nurse-midwife	30	
Nurse practitioner	30	
Physician assistant when practicing in a FQHC or RHC led by a physician assistant	30	

\*The Medicaid patient volume methodology will be designated by the State Medicaid Agency and approved by CMS.

# Medicaid

## Incentive Payment Timeframe for EPs

- The State of Hawaii Department of Human Services Med-QUEST Division is responsible for developing the Medicaid Incentive Payment Program for Hawaii.
- Per the Med-QUEST HIT Planning-Advanced Planning Document (P-APD), development of the Incentive Payment Program will begin in October 2010 and be finalized in December 2010.
- The program may begin as early as January 2011. The last year to begin participation is 2016.
- EPs may receive Medicaid EHR incentive payments for up to six years; 2021 is the final year.

# Possible Medicaid Payments by Calendar Year for EPs

Year	Medicaid EPs Who Adopt In					
	2011	2012	2013	2014	2015	2016
2011	\$21,250					
2012	\$8,500	\$21,250				
2013	\$8,500	\$8,500	\$21,250			
2014	\$8,500	\$8,500	\$8,500	\$21,250		
2015	\$8,500	\$8,500	\$8,500	\$8,500	\$21,250	
2016	\$8,500	\$8,500	\$8,500	\$8,500	\$8,500	\$21,250
2017		\$8,500	\$8,500	\$8,500	\$8,500	\$8,500
2018			\$8,500	\$8,500	\$8,500	\$8,500
2019				\$8,500	\$8,500	\$8,500
2020					\$8,500	\$8,500
2021						\$8,500
<b>TOTAL</b>	<b>\$63,750</b>	<b>\$63,750</b>	<b>\$63,750</b>	<b>\$63,750</b>	<b>\$63,750</b>	<b>\$63,750</b>

# Special Note for Pediatricians

- The total for pediatricians who meet the 20% patient volume, but fall short of the 30% patient volume, is \$14,167 in the first year and \$5,667 in subsequent years. This adds up to a maximum Medicaid EHR incentive payment of \$42,500 over a six-year period.

# Need Help Reaching Meaningful Use and Applying for Incentives?

Let Hawai'i Pacific  
Regional Extension Center (HPREC)  
Be Your Bridge to Meaningful Use of EHRs.

# Hawai'i Pacific Regional Extension Center Provider Requirements

The HPREC was specifically created to work with priority primary care providers, as designated by ONC.

## Requirements to Be Considered a Priority Primary Care Provider (PPCP)

Credentials must be MD, DO, NP, PA, or CNMW

Specialty must be Adolescent Medicine, Family Practice, General Practice, Internal Medicine, OB, GYN, Geriatrics, or Pediatrics

Practice must be a Private Practice of 1-10 Providers, Rural Health Clinic, Community Health Center, Critical Access Hospital, Public Hospital, or Other Underserved Setting

Practice must be in Hawaii

# The Mission of the HPREC



The mission of the HPREC is to support physicians in the adoption of electronic health records (EHRs) and assist them with their progress toward achieving Meaningful Use.

# Why Work with the HPREC ...

- Committed to helping physicians reach Meaningful Use.
- Experienced in a variety of areas, including workflow redesign and information technology.
- Vetted list of certified EMR vendors and can help negotiate contracts.
- Help with pre- and post-assessments that may not be carried out by EMR vendors.
- Help physicians report on MU in order to apply for EHR incentive payments.
- Provide guidance on privacy and security best practices.

# Service Areas

## EHR Technical Assistance & Training to Priority Primary Care Providers

- Supporting Providers with Individualized and On-site Technical Assistance
- EHR Vendor Selection & Group Purchasing
- Effective Implementation of a Certified EHR
- Clinical and Administrative Workflow Redesign
- Functional Interoperability and HIE
- Privacy and Security Best Practices
- Support in becoming eligible for the incentives offered by CMS for achieving Meaningful Use
- Local Workforce Support

# How Long Will It Take to Implement an EHR System and Reach Meaningful Use?

# Example Timeframe

Tasks	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Month 7	Month 8	Month 9
Register with the HPREC	█								
Develop a customized service plan and create EMR ROI	█								
Review current database	█	█							
Provide survey to assess site EHR readiness	█	█							
Choose an EHR vendor	█	█							
Provide recommended timeframe to address barriers and train staff		█							
Map workflow		█	█						
Identify hardware needs		█	█						
Preform gap analysis			█	█					
Install hardware				█	█				
Create Meaningful Use workplan				█	█				
Evaluate physician and staff readiness				█	█				
Train physicians and staff on new EHR processes				█	█				
Information patients about the new system and benefits					█	█			
Build interfaces					█	█			
Test go-live						█	█		
Go live							█	█	
Use certified EHR tech in a meaningful manner							█	█	█
Use certified EHR tech to submit quality reporting and other measures							█	█	█
Use certified EHR tech for electronic exchange of health information							█	█	█
Achieve meaningful use									█

# When Will EPs Receive Payments?

- Example Scenario
  - **Jan. 2011:** You sign up with the HPREC.
  - **Sept. 2011:** You reach Meaningful Use (MU).
  - **Oct. 2011 – Dec. 2011:** You attest to MU.
  - **Jan. 2012:** You submit required reports.
  - ***Feb. 2012: You receive your EHR Incentive Payment.\****

\*CMS has indicated that it will make payments on an annual basis.

# Why Start Now?

- EPs do not qualify for Medicare initial payments after 2014.
- Starting in 2015, an EP who does not successfully demonstrate meaningful use will be subject to reduced Medicare physician fee schedule payments.
- After 2012, total Medicare payment available drops by \$5,000 each year.
- The Hawai'i Pacific REC is available to help you reach Meaningful Use and submit the required reports to become eligible for EHR incentive payments and to avoid potential financial penalties.

# By Successfully Implementing an EHR System and Achieving Meaningful Use, Physicians Can:

- Improve patient care
- Improve operational efficiency
- Reduce operating costs
- Receive financial incentives
- Become part of a state-wide information network for the exchange of electronic health records

# How do physicians enroll?

Contact Alan Ito  
at 808-441-1429 or  
[aito@hawaiihie.org](mailto:aito@hawaiihie.org).

Or visit [www.hawaiihie.org/rec](http://www.hawaiihie.org/rec)  
for more information.

