Washington Health Information Technology Updates

August 2016

Need Help?

Clinical Data Repository (CDR):

Need CDR help? Please contact our team at: healthit@hca.wa.gov and put "CDR" in the subject line or visit our website at http://hca.wa.gov/about-hca/health-information-technology/health-information-technology

To take the first readiness steps in adopting the CDR please visit the OneHealthPort readiness page.

Electronic Health Records (EHR):

Need EHR help? Please contact our team at: healthit@hca.wa.gov

Website: http://hca.wa.gov/about-hca/health-information-technology/health-information-technology

Security or log-in issues with ProviderOne? Please contact: ProviderOneSecurity@hca.wa.gov for assistance with your P1 password or when you have a change in staff resulting in a new System Administrator for your office.

- CMS EHR Help Desk: 1-888-734-6433 Option #1.
- CMS Account Security and to update your accounts contact person: 1-866-484-8049 Option #3.
- Did you know that CMS has its own Listserv? To subscribe: Subscribe to CMS EHR Incentive Programs Listserv.

Remember to keep an electronic back-up or file of all documentation/reports used during each attestation. This will save you considerable time and efforts if you

WASHINGTON Link4Health

A Message From Washington State's Health IT Coordinator

It's mid-summer already and provider organizations with certified EHR systems are working in good faith to meet the February 2017 deadline to submit care summaries each time they see an Apple Health consumer!

I often get asked how this new requirement for provider organizations with EHR systems to begin submitting care summaries fits within or fits under the meaningful use program.

The Link4Health Clinical Data Repository (CDR) serves as a foundational element to support the broader initiatives that the Health Care Authority has underway in the Governor's Healthier Washington Plan. The emerging needs for new data sets beyond historical claim and encounter data include clinical summaries, shared care plans and assessments and an increased need for notifications across care settings.

As more organizations are working to better measure health outcomes, access to full clinical records that reflect care given across the community has become a key driver. Although participation in the CDR it is not a direct requirement of the meaningful use program at this point in time, many providers have not been able to meet meaningful use requirements for sharing care summaries with others. These providers can now meet this objective by contributing care summaries to the CDR.

Some providers have been able to share care summaries using a methodology that delivers patient information directly to the next provider of care. This is an effective method when it is known who the patient will see or has been referred to. In many cases, it may not be known who the patient will need to interact with for care or where they may need to be seen.

In recent weeks, HCA has been meeting with various provider groups who aren't typically part of the direct sharing of health information and need more timely, on demand access to patient's medical records. The following are examples of business needs that have been further validated during our focus groups:

For example:

are ever asked to provide attestation materials during an audit.	• Medical staff that provide care in a jail setting receive little or no information about a person's health status and care needs. During the intake process, an individual may disclose some of their medical information but most often this information has to be collected and validated using phone and fax – if a provider of care is known. Access to information about communicable diseases, medical conditions and medications is needed within the first 72 hours. At the time of intake, the following information is important: • Diagnoses, conditions and treatment history • A comprehensive list of medications for all conditions, including scheduled medications • What providers are managing or coordinating treatment • Immunizations, communicable disease status, behavioral health issues This information will be made available through a web based clinical portal in the CDR. • Patients who change from one managed care plan to another are assigned a new primary care doctor who will not have seen this patient before. Having access to the patients full record saves time and reduces the need for duplicative tests and diagnostic procedures. Providers can either use their EHR system to pull the information in from the CDR or view the information through a web based clinical portal in the CDR. • Behavioral health providers need access to timely medical information so they have a full picture of the patients' conditions, care and needs in in order to make informed decisions, particularly when prescribing medications. Claim and encounter history often lags and will not provide details around results of diagnostic tests and other health information. Without direct access to this information, time is spent requesting records and health information by phone and by fax. Providers across all spectrums of care indicate they would rather spend this time caring for patients. • Medical providers working to deliver whole person – integrated care need access to the records contributed by others. Having physical, dental, and mental health care information in one place increases the ability to deliver integrated care. In a future stage, substance use disorder information will be made available with patient consent. • Care planners working hard to manage the health of their patients spend a significant amount of time calling known care givers and facilities trying to determine if a patient has been hospitalized or entered the jail system after missing planned care appointments. They can often work with their patient to divert them from the jail system and/or coordinate care with the jail so that their clients do not risk further decline. Having access to information can help them identify recent care providers and settings. • There are many others providing services to Apple Health patients who need access to this information such as first responders and long term care providers in home and rehabilitation and post-acute care settings. These examples shared by participants in our focus groups and in other discussions speak to the immediate need for information for the purpose of treatment and care planning. There are a number of other uses of data collected in the CDR that have potential to reduce the administrative burden for providers and managed care organizations to fulfill reporting requirements and for the measuring health outcomes. We recognize that this effort to automate this level of data sharing results in a work effort for your EHR vendor and your staff. We fully expect that many, including your own organization can benefit from the access to this data as they see patients that have received care in other settings.

We appreciate your engagement and efforts in this initiative as we work collectively toward 2017!

Seeking Input Related New HITECH Investment Opportunities!

The link to a survey to capture feedback from the broad provider community and other stakeholders can be found at:

https://www.surveymonkey.com/r/HCA_Env_Scan

HCA is now pursuing federal monies for expenditures related to connecting organizations who need to electronically coordinate care and share information across care settings. HCA can now better support all types of providers serving Medicaid consumers including medical providers, behavioral health providers, substance abuse treatment providers, long-term care providers (including nursing facilities), home health providers, pharmacies, laboratories, correctional health providers, emergency medical service providers, public health providers, and other Medicaid providers.

To inform our initial request, HCA will conduct a multi-year environmental scan to better understand the current state of interoperability between Medicaid providers and to develop a prioritized investment plan to further advance the level of health information sharing needed to support Healthier Washington initiatives and person centered care.

We are compiling results from the main survey period in July. However, if you have not had an opportunity to provide feedback**, we still strongly encourage your participation as soon as possible.**

Collecting Provider Executive Leadership Contact Information

HCA's Health Information Technology team collecting contact information from Provider Executive Leadership. It will be used to send occasional healthcare leadership meeting invites and to provide updates on important new initiatives. Please submit the completed survey no later than Friday August 5, 2016. Thank you.

Clinical Data Repository (CDR) and HealthIT in Washington State

In collaboration with the state HIE, OneHealthPort (OHP), we have continued preparations for the CDR rollout later this year. Activities have been underway in several areas:

- Meeting with providers and vendors to troubleshoot technical and other challenges
- Continuing monthly webinars with various stakeholder groups (e.g. professional associations)
- Analyzing relevant policies and procedures for changes needed due to the CDR
- Working with DSHS and DOH to identify CDR users and business process impacts
- Finalizing a data classification white paper (version 1) as guidance for EHR vendors and providers as they prepare their data (i.e. assigning standard confidentiality codes) before sending to the CDR

- Addressing technical and policy questions related to the Provider Directory and to setting triggers for sending the care summaries to the CDR
- Working with the Office of the National Coordinator (ONC) that oversees the certification of electronic medical records to discuss certain technical requirements

In addition, OneHealthPort is offering monthly webinars for EHR vendor and provider organizations. Their readiness efforts are continuing in parallel with those of the state. The links below contain more information:

- EHR Vendor webcast: https://onehealthport.formstack.com/forms/cdr_technical_webcast_registration
- Provider and Staff webcast: https://onehealthport.formstack.com/forms/cdr_clinical_webcast_registration

If you have any questions about whether your organization is required to submit data to the CDR, please refer to the decision tree on the HCA website or email us at healthit@hca.wa.gov .

Attestation Alert:

Processing times have slowed due to the CMS Stage 2 new rule change delay. We have received a high volume of 2015 MU and 2016 AIU attestations and when we go live with 2016 MU attestations we expect an even higher amount. We are trying to work in date-received order and are being diligent with your attestations to make sure they are handled accurately. Processing can take between 4-12 weeks if all needed documentation has been uploaded into each attestation.

What can you do to speed up your processing?

Make sure that you have supplied the information on the Documentation Checklist on our website.

Hover over LIBRARY AND TRAINING RECOURCES and choose ELECTRONIC HEALTH RECORDS LIBRARY. Look under HELPFUL TIPS for the AIU and MU Document Checklist.

HCA is preparing a short webinar titled DOCUMENT CHECKLIST to help providers gain a better understanding of what documentation is we require per Federal Guidelines. This webinar will be available Thursday July 28th on our website.

EHR Alerts

When contacting us with questions, please be sure to use the same email you used when registering at CMS. Otherwise we are unable to assist you.

2016 is the last year to initiate participation in the Medicaid EHR Incentive Program. For more information on eligibility please visit our EHR Incentive Program Overview page.

Final Rule changes to affect provider attestation application eMIPP

In October 2015, CMS released a final rule that specifies criteria that eligible professionals, eligible hospitals and CAHs must meet in order to participate in the EHR Incentive Programs in 2015 through 2017 (Modified Stage 2) and in Stage 3 in 2017 and beyond.

2016 Program Requirements

Here's what you need to know about meeting EHR Incentive Programs requirements in 2016:

Objectives and Measures

- All providers are required to attest to a single set of objectives and measures. This replaces the core and menu structure of previous stages.
- For EPs, there are 10 objectives, and for eligible hospitals and CAHs, there are 9 objectives.
- View the 2016 Specification Sheets for Eligible Professionals and Eligible Hospitals and CAHs.

In 2016, all providers must attest to objectives and measures using EHR technology certified to the 2014 Edition. All providers may attest to objectives and measures using EHR technology certified to the 2015 Edition, or a combination of the two (if the 2015 Edition is available).

Alternate Exclusions

- EPs, eligible hospitals and CAHs that were scheduled to be in Stage 1 in 2016 may claim an alternate exclusion for an EHR reporting period in 2016 for Objective 3: Computerized Provider Order Entry, Measures 2 and 3 (lab and radiology orders), or choose the modified Stage 2 objective and measures.
- Eligible hospitals and CAHs that were scheduled to be in Stage 1 in 2016, or were scheduled to demonstrate Stage 2 but did not intend to select the Stage 2 eRx objective for an EHR reporting period in 2016, may claim an alternate exclusion for an EHR reporting period in 2016 for Objective 4: Electronic Prescribing or choose the modified Stage 2 Objective.
- Providers scheduled to be in Stage 1 and Stage 2 in 2016 may claim an alternate exclusion for the Public Health Reporting measure(s) that might require acquisition of additional technologies that they did not previously have or did not previously intend to include in their activities for meaningful use. EPs may claim an alternate exclusion for measure 2 (syndromic surveillance) and measure 3 (specialized registry reporting). Eligible hospitals may claim an alternate exclusion for measure 3 (specialized registry reporting
- Review this fact sheet for an overview and more details about alternate exclusions for certain objectives and measures in 2016.

Changes to Specific Objectives

- The Objective 9, Secure Electronic Messaging: This objective has a phased approach for its measure's threshold. For 2016, the measure is "For an EHR reporting period in 2016, for at least 1 patient seen by the EP during the EHR reporting period, a secure message was sent using the electronic messaging function of CEHRT to the patient (or the patient-authorized representative), or in response to a secure message sent by the patient (or the patient-authorized representative) during the EHR reporting period.

- Objective 10, Public Health Reporting: In 2016, all EPs must meet two measures, and eligible hospitals and CAHs must meet three measures.

View objective and measure tables for Eligible Professionals and Eligible Hospitals and Critical Access Hospitals.

complex if the information were presented in the same way that the attestation system functions.

Requirements for EHR Incentive Programs in 2016 Resources

- Eligible Professionals: What You Need to Know for 2016
- Eligible Hospitals and CAHs: What You Need to Know for 2016
- Health Information Exchange Fact Sheet
- Broadband Access Exclusions Tip Sheet
- Security Risk Analysis Tip Sheet
- Patient Electronic Access Tip Sheet
- Eligible Professionals: Public Health Reporting in 2016
- Eligible Hospitals: Public Health Reporting in 2016
- Guide for Eligible Professionals Practicing in Multiple Locations

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Hospitals:

Paid for Year 1	= 88	$63,781,127.00
Paid for Year 2	= 78	$35,845,012.00
Paid for Year 3	= 64	$24,444,670.00
Paid for Year 4	= 45	$13,706,932.00

Eligible Providers (EP):

Paid for Year 1	= 6,215	$131,445,446.00
Paid for Year 2	= 2,619	$22,128,349.00
Paid for Year 3	= 1,486	$12,614,002.00
Paid for Year 4	= 427	$3,626,667.00
Paid for Year 5	= 50	$425,000.00

GRAND TOTAL PAID

SINCE 6/1/2011:	=	$308,017,205.00