NWX-HHS-OS

Moderator: Pamela Kania
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Coordinator: Welcome and thank you for standing by. At this time all participants on a listen only mode until the question and answer period. If you'd like to ask a question at that time please press star then 1.

Today's conference is being recorded. If you have any objections you may disconnect at this time. Now I'd like to turn over the meeting to Marilyn Keefe. You may begin.

Marilyn Keefe: Good afternoon. I'm Marilyn Keefe, the Deputy Assistant Secretary for Population Affairs. I'm here with Pam Kania from OPA as well.

Welcome to our inaugural webinar. Today we're focusing on health information technology, meaningful use and Title X. We know that the use of HIT has the potential to reduce administrative costs, increase staff efficiency, improve care coordination, reduce medical costs of medical errors, and otherwise improve the healthcare system for providers and patients.

The HITECH Act included in the American Recovery and Reinvestment Act put in place a variety of incentives and policies to infer adoption and use of HIT including substantial financial incentives to individuals, Medicaid and Medicare providers including nurse practitioners to adopt and demonstrate meaningful use of EHRs.

The law also created the Office of the National Coordinator for Health Information Technology which is charged with establishing national

standards, certifying technology, coordinating and enforcing HIT privacy policies and in general supporting the adoption and effective use of HIT.

Part of the charge is also to oversee Regional Extension Centers that offer technical assistance to help small and financially challenged providers, (we) Title X, adopt electronic health records. We know the family planning agencies are intent on adopting this new health information technology envisioned under the HITECH Act but that many face a host of challenges ranging from cost to confidentiality to how best tailor these technologies to the specific requirements of Title X.

To discuss some although by no means all of the questions and concerns relevant to family planning providers, we've gathered three extremely knowledge HHS panelists. There'll be an opportunity to ask questions verbally or by typing them in after the completion of all the presentations and we'll give you more specific instructions when we get to that portion of the agenda.

Our first speaker is Jessica Kahn, the Technical Director for Health Information Technology at the Centers for Medicare and Medicaid Services. Jessica has worked for more than 15 years at both the state and federal levels in healthcare service delivery, program management and evaluation. She's also worked in the Family Planning Program in Louisiana which gives her real credibility in our universe.

Her presentation today will focus on EHRs and Medicaid incentives.

Our second speaker is Joy Pritts. She's currently the Chief Privacy Officer with the Office of the National Coordinator for HIT. In this role she provides

critical advice to the Secretary and to the National Coordinator in developing and implementing ONC's Privacy and Security Programs.

Prior to joining ONC Joy was on the faculty at Georgetown University. Her work is focused on the critical issues surrounding the privacy of health information and patient access to medical records at both the federal and state levels. Joy is a real expert on the HIPAA privacy rule and for many years has worked closely with National Consumer Organizations and federal policymakers to ensure the protection of health information.

Our final speaker is Matt Kendall, the Director of the Office of Provider Adoption Support that's also within the Office of the National Coordinator for HIT. Matt's office is responsible for administering the Regional Extension Center Cooperative Grant Program which is working with organizations across the country to assist primary care providers in priority settings such as Family Planning Clinics to achieve meaningful use of EHRs.

Prior to working at ONC Matt was the Director of Operations for the New York City Department of Health and Mental Hygiene's Primary Care Information Project which helped primary care providers and medically underserved communities adopt electronic health record systems. Prior to that Matt served as Executive Director of the Indian Health Center of Santa Clara, California, a federally qualified health center in San Jose.

So now to our first speaker, take it away Jessica.

Jessica Kahn: Thank you, and oh great, so we've teed up my slides. I'm really actually very thrilled to be here with all of you today this afternoon. It just shows that life is very circular.

So as Marilyn had mentioned in the late 90s and early 2000s I was the Title X Director for Louisiana and had a obviously close personal relationship with OPA and with their Region 6 staff.

And so it's a pleasure to be with you all once again to talk about something slightly different but still very, very much applicable to family planning.

So here at CMS I work on the Medicaid side of the house so I'm going to focus on the Medicaid EHR Incentive Program. And besides giving you an overview I'll try to point out some issues and specific things that I think are directly relevant to either family planning providers or family planning programs as a whole.

All right so let's see. It works. I love it.

Okay so just some level setting here this came out of the stimulus bill otherwise known as the Recovery Act from February of 2009. And between then and July 28, 2010 we worked feverishly to produce a final rule. It was put out for public comment seven months prior to that. We received thousands of comments, adjudicated them and put out the final rule in late July in the Federal Register.

So the Medicare EHR Incentive Program which includes both fee-for-service and managed care is administered by CMS here at a federal level. The Medicaid EHR Incentive Programs are being administered and implemented by the State Medicaid Agencies.

And I'll point out some places where at the federal level we provide - how we provide funding and where we have a stake and where we have a (carrot) and so forth.

Okay, so who is the Medicaid eligible provider?

So the - we call them EPs, eligible professionals. And there are five types. They are physicians, and let me just say that physicians are defined as a doctor of medicine or osteopathy; nurse practitioners, certified nurse midwives, dentists and physician assistants but in a more limited way. They are only physician assistants who are working in a federally qualified health center or rural health clinic that is led by a PA.

And in our final rule we define what led by means. Essentially they're the Clinical Director. They see the majority of the patients or they're the owner of the FQC or rural health center if that could be possible.

And then there are some eligible hospitals and that's acute care hospitals which includes critical access hospitals -- lots of acronyms on this slide, I apologize -- and children's hospitals.

Okay so if that wasn't enough there's - so that's step one, so are you one of those entities on the left hand column.

Step two is this issue of patient volume unique for Medicaid. So if you are a provider and you are at any other - you practice at any other location other than FQHC or RHC which I'll get to in a moment, you have patient volumes that you see in the middle column.

So a physician is 30%. Pediatricians do have a slightly lower percentage at 20%. Dentist, you see it goes on down the list. Children hospitals have no minimum patient volume but you can see acute care hospitals have 10.

So we define patient volume in a number of different ways that I'll get to in a moment.

Now the alternative is if you are a eligible professional who practices more than 50% of the time in an FQHC or an RHC in which case your patient volume can be calculated by needy individual, and I'm going to define that.

The next slide or one right after that, okay so let me just, if you're looking at Slide 4 again you'll see we have all these different entities on the left hand side.

And so I want to just make sure that we're clear here. Clinics are not one of those entities. There are eligible professionals and there are eligible hospitals. Clinics are not directly eligible for the Medicaid or Medicare for that matter, EHR Incentive Program payments.

However if the practitioners at the clinic meet the eligibility criteria that I'm going through with you and they successfully adopt, implement, upgrade or meaningfully use, all terms which I'll get to in a moment, certified EHR technology they may choose to reassign their incentive payment to their clinic.

So what that means is when they register for our program and they put in the Tax ID Number where they would like the check to be sent or to who it would be sent they could use their own or they could reassign it to the clinic and that clinic would need to have that Tax ID Number already established with the Medicaid agency because they have to have some fiscal relationship. But there's a process to be able to do that.

So one of the questions that we receive quite a bit and when people say, "Well how can a clinic make the providers reassign their payments if we're the ones

that are putting out all the money for the electronic health records and the providers get to keep the money, how is that fair?"

And CMS's answer to that is we would hope that providers who are working in your clinics have employment contracts or some sort of an employment agreement which has terms by which you have some leverage. So you can if you so choose, renegotiate some of those. And I'll talk more about that in a bit.

So patient volume, patient volume is defined by two primary ways. Looking at encounters so that's clear, that's the flow of people who are coming through and how many encounters you would have. So they have to have 30% of their patient volume within a 90 day period and they can pick any consecutive 90 day period within the prior calendar year.

So if there's a peak, you know, in the late fall, early winter when everyone's got the flu or getting a flu shot that's okay. You can pick your highest point within the calendar year, your highest 90 days.

So that's encounters. The other way to look at it is a patient panel. For those who are working in a managed care environment or a medical home you can look at who's assigned to your patient panel and nurse parameters around that.

So states can pick one or more of these ideas or propose a new one and CMS will review it and approve it.

And if one state gets very creative with how they're going to track patient volume and when it's approved by CMS then it would be considered a new option for all states.

Okay, so again encounters are for both fee-for-service, for managed care and medical homes and then for hospital.

So let's talk about practices predominantly in needy individuals because this has to do with those of you who work - whose family planning clinics are also community health centers, FQHCs or RHCs.

If an eligible professional practices more than 50% of their encounters over a six month period at either an FQHC or an RHC then they can calculate their patient volume by broader than just Medicaid. They could include Medicaid or CHIPS so Title XIX or XXI, patients who are furnished uncompensated care or sliding fee scale or no cost of care so that's, you know, virtually everyone who comes into an FQHC or RHC with the exception of Medicare.

So this is a much easier route to meeting the patient volume requirement. But again it's only for the FQHCs and the RHCs that are defined by law. This is not - we can't decide to add other kinds of clinics and call them an FQHC or an RHC such as the family planning clinic or a free clinic or a community mental health center. It is those that are defined as an FQHC which is still broader than what we normally consider. It includes the migrant clinics, the healthcare - the homeless clinics and a few others.

But that's a term that was already defined in law.

Okay, wait. One more quick thing I want to mention here about patient volume and that's that in the final rule we allow for providers to calculate it across the whole clinic. So let's say your family planning clinic has three nurse practitioners and two doctors.

Do all five of them individually have to have 30% Medicaid patient volume?

Well that's one way of looking at it. The other way of looking at it is if all five are eligible professionals and when you look at their volume all together it's on average 30% or higher, then they can use that group patient volume as their proxy. So that kind of can pick up the outlier if need be.

But you have to go all or none. You can't have, you know, two of them going with the group level and three going with the individual so they kind of have to make a collective decision and figure out what would be the most beneficial way for them to qualify with patient volume.

So another way that Medicaid is different from Medicare is that in your first participation year and this is not a calendar year issue. This is the first year you come into the program which will start in 2011 and run through 2021. You don't have to demonstrate meaningful use right out of the gate. The Medicaid providers only need to demonstrate that they have adopted, implemented or upgraded certified EHR technology. And I'll explain what each of those terms mean.

But then in their second and subsequent years they do have to demonstrate meaningful use. So this is a very important cohort.

That said as you'll see in a little bit the first year's check is the largest so it's important that people understand that this can get them started. So for people who are concerned about cost again this could be just at the adoption phase where you have incurred some financial or legal responsibility so you purchased it or you leased it or you have a user agreement or a license agreement, something that is proof of adoption.

We're not really concerned so much about implemented yet because everybody's going to either adopt something that it's certified per the new ONC criteria or they're going to upgrade meaning they already have something and now they're going to get the latest version. So people are calling it like the meaningful use release or something for the new certified standard.

So everyone would either adopt or upgrade and they would demonstrate that to the state Medicaid agency that they have done so and there's no reporting period. That's not something you have to sustain. You do it today and it's done so we could start to see some incentive payments there before we get to meaningful use.

So let's talk about meaningful use. So in the Recovery Act they actually hit on three elements of meaningful use that regardless of the public comment period or any of the thought put into it by HHS are going to be part of the final definition no matter what.

And these were those three. They were use of certified EHR technology in a meaningful manner such as ePrescribing, the use of it for electronic exchange so again not just discharging records and keeping them in the same office but really focusing on health information exchange and moving that data across the patient's continuum of care.

And then using certified EHR technology just to make clinical quality measures and this is important because we're starting to see how this could force out to the linkages with actual outcome.

So what we laid out in the final rule is our conceptual approach. And this was also supported by we have a Federal Advisory Committee. The HHS Policy

Committee has a Meaningful Use Work Group. And there were a number of different hearings and Medicaid agencies in states and many others had a variety of ways to contribute to this model.

But the idea is this. In the beginning we just have to get the data in these things, right. These are tools and there's not a whole lot of point going too far down the line in terms of clinical decision support or looking at outcomes if you don't have the data in the tools to start with.

So first we have to capture the data, capture it in a standardized way, make sure it's shared at a limited extent such as with a lab or a pharmacy or an immunization registry or public health but really get it in there, get it defined in a consistent way.

And then Stage 2 of meaningful use we'll have a greater emphasis on advanced clinic processes and clinical decision support, etcetera, and Stage 3 improve outcomes.

Each of the future stages is going to have another rule making attached to it with opportunities for public comment. And at each point we need to stop and assess where we've gotten with the prior stage to help us inform what the future stages are going to look like.

So these are the priorities for Stage 1. I think these would resonate very much with family planning. So it's about using the health information technology, the EHRs to improve quality, safety, efficiency and reduce disparities, to engage patients and families in their healthcare, to improve care coordination, to improve population and public health and of course underpinning everything is privacy and security protections which Joy will talk to you about in a bit.

Okay, so Stage 1 which is just for 2011 and 2012 some of the meaningful use objectives and each objective has a measure associated with it, for some of them 80% of the patients have to have their records in the certified EHR technology.

And I point that out because adopting EHR is not something that happens overnight. There's a transition. What do you do?

Each of you have been in clinics, you've done the quality reviews. You see these rooms full of charts.

Well how do they get from the big room full of charts to having it all digitized in an EHR?

So there's different approaches to that, some people just move prospectively forward, some do it retrospectively slowly, some prioritize which they scan. But scanning has limitations which I'm not going to get into right now.

But at least 80% of the patients have to have their records in the certified EHR technology to meet some of the objectives.

So an eligible professional has to pick 20 out of 25 meaningful use objectives. So they have some flexibility there.

Eligible hospitals have to report on 19 of 24 so they too get to defer five.

And for meaningful use in the provider's first year that they're demonstrating meaningful use which again for Medicaid could be their second year of an

incentive it's just for 90 days. So whatever you do you have to hang in there for 90 days and demonstrate that you've done that for 90 days.

However the next year that you demonstrate meaningful use it's going to be 12 months.

And we actually think that while people feel happy about the 90 day thing and they feel like it's somewhat easier, you know, once you start ePrescribing it's not like the 90 day, a bell's going to go off in the clinic and everybody's going to put the computers down and power them off and pick up paper pads again for prescribing. I mean I think there's - one of the things that Matt's going to talk about is all the effort that goes into workflow redesign and training your providers and using this to optimize care and even administrative processes so no one wants to go back.

Find me a provider who uses an EHR and wants to go back and I'll be shocked.

So this is more for your reference. I don't usually like to throw so much information up on a slide but these are some of the core set of objectives. So this is the 15 core objectives. Again they're picking from - I'm sorry, these are the ones they don't pick from. These are the ones the eligible professional has to do.

For each of these objectives as I said there's an associated measure. But you can see these are fairly fundamental things that either start to capture information that is necessary for other things to work.

So for example if you don't have an active medication list for your providers there's not a whole lot you can do on medication reconciliation or some of the

other steps. You need to have the vital statistics and the demographics and that information in there.

And we wanted to make sure that in the course set there were things that really resonated with patients such as providing a clinical summary for patients after each office visit or giving them access to an electronic copy of their health information upon request.

And then privacy and security was nonnegotiable for the course set.

And there's - this is the course set for hospitals. So it's slightly different. It doesn't have ePrescribing on there. But for the most part it is the same as the eligible professionals.

So then they have this menu set as we said that they get to choose from. So how do they choose? What are they going to decide?

Well some of it's going to have to do with what is easiest for them with their workflow or maybe it resonates with them. This is the thing they want to tackle. Or it might have to do with their surrounding.

So for example incorporating clinical lab results into your EHR structure data, if you live in a place where there aren't any labs that are sending electronic results in structure data that might not be the menu measure that you select.

Similarly if there is one that is easy for you because your state lab does that or the state lab plus two or three of the big labs and so that's something you think you can do then you might defer one over the other one. You do have to pick one that's "Public health-related." And those are testing the submission of data to immunization registries, person (from surveillance). And then for

eligible hospitals it also includes submission of reportable lab results. So an EP would have to pick up from at least one of those on the prior slide and the hospital would have to pick one of these three on this hospital (slide).

Okay, so the applicability question comes up a lot. People say I don't see myself in these meaningful use objectives.

For example and I have chiropractors on here even though they're not eligible for Medicaid but we use this slide for Medicare as well. But let's take certified nurse midwives. They don't prescribe. Well if they don't prescribe and that's not applicable to that clinical practice that's an example of a meaningful use measure that does allow them to be excluded.

That's not true for all of them. There are some that people are going to argue aren't applicable to them. But we say that they should be such as for example screening for tobacco use.

So some of them are going to be applicable and some of them aren't. But dentists don't perform immunizations, nurse practitioners, I mean sorry, nurse midwives do not ePrescribe. So these would be examples of the applicability issue.

So one of the things that we allowed for and you might have heard about is states taking this floor definition of meaningful use for Medicare and Medicaid and tweaking it for their state situation. So we allowed for that.

But subject to CMS prior approval but only where it related to public health because we wanted to make sure that people understood that the connection between meaningful use and public health is essential in order to achieve the goals of those priorities that we talked about at the beginning.

So states can do a few different things with these measures. They could move them from the menu set to the core set so all providers would have to do those and so that would be a shorter list of things that they could pick from from their menu set and/or they could leave them where they are and just put a finer point on it.

For example one of the measures that we call Public Health S, it's not exactly public health, but it could be a powerful tool so we added it, is generating lists of patients by specific conditions for quality improvement, disparities, research or outreach.

So we just say that they need to generate a list like that one time within the 90 day period in their first year of demonstrating meaningful use and then at least once in the subsequent years. Well that's just generating a list by specific conditions. That doesn't necessarily tell you anything.

But let's say you're in a state that's really focusing on obesity. And you are doing population level issues, population level activities on this. You're really trying to draw provider's attention across their practice not just at the individual patient. But how are they managing people with obesity across their whole practice?

So you could say to them for meaningful use in our state we want you when you do that on that measure or if you select it, we want it to be that you generate a list of your patients by obesity. And then it's not meant to be reported. It's meant to be a QI tool so that they would start to track that or childhood obesity or hypertension or diabetes or whatever it is, it's to reinforce to the provider that the tool, the technology that has taken their paper chart and put it into an electronic format now allows them to see more than

just Jessica Kahn's chart. Now they can see how I fit across the benchmark, across all of their patients who share a certain common thread with me so it allows them to have a - take a step back and see their patient records at a more macro level that they couldn't do before.

And this could possibly be something the state would want a provider to do that costs them no extra, it's no particular extra burden but it could be a tool.

Likewise they could tell them, you know, we have five immunization registries but this is the only one that we're investing in moving forward for interoperability and so forth so we want you to test with that one. So they could be a little bit more specific about how and where they want that data to be tested for public health.

So the states would have to submit these requests to CMS. They would have to justify it to us. Show that it doesn't increase provider's burden or cost. That it's permissible and accessible across the whole state. And then we would approve it.

And I have to say to date we haven't seen any states coming in with this yet. Though they all reserve of course the right to think about it at a later date because it's not a one time offer that expires.

So I was thinking about also for family planning and this is often the case with the clinics that I worked with in Louisiana, they have a lot of providers who work at multiple locations. And so how do you handle those people for meaningful use especially if not all the locations are going to have certified EHR technology?

So in order for them to participate they have to have at least 50% of their total patients at a location or locations, plural, where certified EHR technologies available.

So if they work in three different clinics and two of the three have certified EHR technologies then at least half their patients have to be in those other two clinics that have it.

And of course logically you would only base your meaningful use measures on the encounters that happened where the certified EHR technology is available. We're not going to measure your ePrescribing in the clinic where you have no capacity to ePrescribe of course. But no snickers allowed but you know I had to sort of put that in there because I keep getting questions about these things.

Okay, meaningful use Stage 2, as I mentioned we intend to propose two additional stages for future rule making. They're going to build upon and expand upon Stage 1.

So for example we might see some of the menu set option measures being moved into the core set. But we also need to reevaluate the measures themselves.

So if right now 40% of all lab results would come in a structured data format would we increase that? Or on the other hand we might need to look and see where things were not successful in Stage 1 and it wouldn't be proper to either raise the bar or even to move them into the core set or Stage 2.

There is going to be greater emphasis on health information exchange across institutional boundaries. The federal government is leveraging a lot of

resources at the state level to support the capacity for health information exchange across clinics and hospitals and providers and labs and other trading partners and so it's very important that we continue with that momentum.

I just want to note because this comes up also that additions to the list of who's an eligible professional and/or this question about allowing clinics themselves to be directly eligible for an incentive and not have to go through the reassignment issue with the providers and any changes to the patient volume threshold, the 30% and so forth for Medicaid. That would require a legislative change.

Those are not things that CMS did as part of rule making. Those were actually in the HITECH legislation. So we can't for example decide that we want to include let's see clinical social workers or that family planning clinics should have the 30% needy individual threshold just like FQHCs and RHCs or that 30% is too high. All of those things would require a legislative change by Congress.

So just quickly about how this is going to work so providers are all going to register at one location, Medicaid or Medicare. It's going to be on the CMS web site. And they're going to provide some basic information there. There are a few things they have to have.

So they have to either be enrolled in Medicare Fee-for-Service, Medicaid Advantage or Medicaid. That I guess goes without saying. They have to have a national provider identifier. And they need to use certified EHR technology capable of meaningful use. So again as I said Medicaid providers can just adopt, implement or upgrade in their first year. They don't need to demonstrate meaningful use but they have to have the certified EHR technology that could do meaningful use for them wherever they so choose.

And Medicare providers and Medicaid eligible hospitals but not Medicaid eligible professionals have to be enrolled in PECOS which is a system that we use here for provider enrollment and eligibility.

And that - the reason for that that they have to have an NPI and that some of the providers not all need to be in PECOS is when they register we're going to try and pre-populate and validate some of that information against these other systems to make it easier all around.

So let's just pick a state say Louisiana. So let's say I'm a provider and I go onto this web site at CMS and I'm trying to figure out there's some nice eligibility wizards helping me determine whether I'm eligible for Medicare or Medicaid or maybe I already had some ideas about that, so I say I pick Medicaid. And then I pick a state, Louisiana. You're only allowed to pick one though you can change your state every year.

You can only switch between Medicare and Medicaid once after you've received a payment but you can switch your state every year.

So let's say I pick Louisiana. So the initial information that was collected by our CMS web site Registration Program will be forwarded then to Louisiana. And they will complete the additional information that's needed in order to generate my payment such as asking me about my patient volume. They'll make sure I'm actually a licensed provider in Louisiana. They'll ask me to attest to having adopted, implement, upgrade or meaningful use certified EHR technology.

And just to clarify by what I mean by attest, you know when you do your electronic taxes you have these electronic forms that you fill out and it has

dropdown menus and it skips certain questions if certain things are not applicable. And at the end you have an electronic signature. So that's an attestation. It's still binding to you so they would ask you to attest to these things.

They would check back with the CMS system before they make a payment just to make sure it hadn't been paid by say Texas or Arkansas or Oklahoma and/or Medicare. And then if not they'll go ahead and issue me a payment.

So again these are some of the requirements that are necessary. We're going to ask for their name, their National Provider Identifier, their address and phone number, their Tax ID Number, if they're a hospital their CMS Certification Number. As I said they have to pick Medicare or Medicaid and they have to pick a state.

So that's fairly basic. So let's move to the dollars quickly. So in the first year it's $21,250, again so that's the provider's first year. It's not calendar year. So this just shows you 2011 through 2016 because you have to start the program in Medicaid by 2016. It continues through 2021. But 2016 is the last year that can be your first year.

So regardless of whether you start in 2011 or 2012 or 2013 it's the same dollar amount. You have six years to get your total which is $63,750.

So that's the amount for the eligible professionals. I don't have a slide that says what the incentive payment amounts are for Medicaid eligible hospitals because it's individually calculated based upon the number of discharges. There's a $2 million base and then there's factors taking into consideration about discharges and the Medicaid share and disproportionate share and

charity care and so forth so that actual hospital amount it varies from hospital to hospital.

Oh look I did put a slide in. There you go. So it's a $2 million base plus the discharge amount. There's no maximum for hospitals and I just wanted to also mention that there are some hospitals, acute care hospitals, that just for your own edification to know this that might be eligible for both Medicare and Medicaid but they're the only ones. Everybody else has to pick something, pick one or the other.

And on the Medicare side they're actually going to have fee schedule or market basket reductions after 2015. If they're an eligible provider under Medicare and they're not meaningful using by 2015 they're going to get less money, right, in the reimbursement. This is not true for Medicaid.

So like if you take home two things from my presentation or three things, let's be clear, it's that clinics themselves are not directly eligible but can ask their providers to reassign their payments. That Medicaid providers can adopt, implement and upgrade and not meaningful use and that there are no payment adjustments under Medicaid if they cannot demonstrate meaningful use.

Okay, so moving along the states are going to receive 90 cents on the dollar from the Feds to run this program. That's a very generous match. They only have to come up with 10% matching fund. The actual incentives the 63,750, is 100% federal; states do not have to come up with a dime for that.

So we don't want to just cut the checks and do some oversight and make sure that they paid the right people for the right amount although that's allowable task. We actually want them to drive the sort of success and promote EHR

adoption and health information exchange. So they should be looking at the infrastructure that they have.

So we ask them to do an as-is landscape of Medicaid and health IT and then to tell us what their plans are for implementing the program. So they should be talking to public health. They should be talking to Title X. They should be talking to the state HIE Program. And anyone else who has a stake in this to determine what their vision should be. And how they're going to implement the program, what are going to sort of the timelines.

One of the questions we get a lot is okay, so Medicare is going to start registration in 2011 for Medicare and for Medicaid. But what's next for the states? When do we know when they're going to start accepting provider attestations or making payments?

Well it's voluntary for states. They set their own timeline. So as Title X Directors who work with a lot of providers some of whom may be eligible for this you might want to have a voice in what that timeline would be and what the implications would be were it to be delayed.

So these plans are meant to be iterative documents, living document. They're supposed to be publicly posted once approved. And they come with a associated funding request for us. So they have to lay out their roadmap and how their blueprint for the program and then ask us for what they want us to pay for part of it because there are other sources of funding for it, other pieces. So we're only paying for part of it though a very significant part.

So again for Medicaid and for family planning even before healthcare reform we're seeing a significant increase in the number of women of reproductive

age who are enrolled in Medicaid. Right now it's almost 15% of all American women of reproductive age are covered by Medicaid.

And 27 states have the 11.15 family planning waivers.

And by the way when we're talking about patient volume that is considered acceptable; it doesn't mean that the whole visit had to be reimbursed by Medicaid. It could also include any services that are covered under the waivers or Medicaid paid any premiums or co-pays or deductibles or was a secondary payer as well.

So this is really important for you all. Medicaid and CHIP pay for four out of ten births in this country. And family planning is part of that cycle.

So in terms of health IT I think one of the things that we try to stress with providers when they ask is so is this infrastructure, you know, is this like something that we should consider if possible.

And we at this point are saying this is the 21st Century stethoscope. This is not infrastructure. This is not optional. This is an essential tool for healthcare service delivery. And there are many different ways that you can look at this but I think either way the train has left the station and this is going to be how medicine is practiced and providers themselves are going to drive this. They're going to make sure that everyone understands that this is the standard of care. And it's as essential as having the exam table and the stethoscope.

So whether you get onboard because of the practice management benefits for billing and eligibility determination and preauthorization and all the way so they can streamline the clinic's administrative role or even ePrescribing, thinking about the refills for contraception and how this could greatly assist

clinics and pharmacists with that not to mention get some useful data on how many prescriptions were actually filled. There's also the emphasis on clinical decision support that could be really critical for family planning around risks and contraindications and missed screenings and so forth.

And then health information exchange is so important in maintaining that continuity of care for our patients as they move from setting to setting.

And I think the linkages to healthcare reform really lend some additional urgency here as you start to see the expansion of Medicaid enrollment on our horizon.

So the next few slides are going to talk about some possible barriers to EHR adoption for family planning providers and what might be some solutions. You know this is not me looking into the crystal ball. I'm not saying we thought of everything.

But these are some initial ideas that might potentially address some of these issues. So cost is a big one. This isn't necessarily unique to family planning providers. But cost for EHR adoptions are high and I do think it's worth pointing out though that it's decreasing that unlike some of other things where the cost in healthcare keeps going up and up and up, as we start to see a greater level of EHR used and more (EHR) software out there the cost can be significantly going down. You don't have to get the Cadillac. There are many versions in between the Yugo and the Cadillac.

So what are some solutions to deal with the cost issue?

For one thing just remembering that adopt, implement and upgrade is possible in the first year so you can outlay the funds and then get your EHR incentive

payment within a fairly close timeframe to each other and that's pretty important.

Again clinics should think about their employment contracts with eligible professionals. If clinics or programs that have multiple clinics or networks or so forth are putting out this funding just like you have an agreement with your employees about using the other equipment or the other services that you make available to them in order to do their job this would be considered something else.

You can be creative here. You can say you reassigned your first year's payment. We'll give you a bonus of X amount for having reached that milestone and then subsequently for meaningful use and so forth. They don't have to take the whole thing.

I should also note that public providers can be eligible professionals. So in Louisiana we had these parish health units that were all state employees so state employees who are eligible professionals are eligible for the EHR incentive payments. This is not only for private sector.

So state, local and county clinics should be considering what this means for them and for the providers who might be eligible within their staff.

And then we also strongly encourage providers to participate with the Regional Extension Centers, FQHC networks and other clinic level consortiums to look at leveraging their purchasing power instead of striking out below and having to negotiate cost and technical assistance and technical support agreements one by one by one.

And Matt will talk more about that in a minute.

All right, so this Medicaid patient volume issue is a barrier we recognize for many providers, again CMS did not come up with that 30% on its own. I did mention that you can use the whole clinic patient volume as a proxy. I did mention that you could pick the 90 day consecutive period peak at the highest point of the year at your leisure to whatever would be most advantageous.

For family planning clinics I remember that there were times particularly with our planned parenthood affiliates there were times when the patient may or may not have been covered by Title XIX but they didn't want it to be known and they didn't want Title XIX to be billed. So you can still query for Medicaid eligibility so this is a Medicaid beneficiary even if you're not billing and keep record and that would count towards your patient volume.

Part time providers so providers who are working both at a family planning clinic and perhaps a private practice or a couple other places, they can calculate their patient volume across all of their clinical settings. They don't have to have it all within that one clinic. If they work across three places it could be across the three places that the 30% comes into play. I mean sometimes that cannot work to your advantage because you're increasing your denominator at the same time as you're increasing your numerator. But it can possibly work.

And then again the 11.15 waiver patients do count for patient volume so keep that in mind.

Privacy concerns are largely going to be addressed by Joy but I would just want to point out here in case I'm not already preaching to the choir that we all strongly believe and there's evidence to demonstrate that this is more secure than paper charts. That when you have patient consent and you have

provider authentication so that only the providers who really truly are seeing that patient and have their need to know can access that information.

And you have a Master Patient Index that's making sure you're actually getting the right record and you didn't pull the wrong one off the rack in the chart room. And you have an automated audit log so you're not relying on somebody remembering to sign a book or to type something in but it's automatically noting who accessed that record and at what time.

And then you've got some very smarter localized business analytics. So what I mean by that is if you're in a state where the - it's a minor and they have certain rights or don't have certain rights to their own information your system can be tailored to that and localized to help support those local security and privacy issues.

So all of that we believe results in enhanced privacy of patient data as compared to paper charts.

So again this is my preaching to the choir slide but I had to put it in there because it just made me so happy to talk to you guys and to remember how critical your role is and your clinic's role is that this the only contact that most women have with the healthcare system.

And that while people talk about primary care providers I think essentially family planning providers are sort of primary care plus. It's basically primary care, you know, plus contraception and some screening.

So it's really important that people see your providers as being right there at the center around primary care. It's such a key population and public health

role. It almost always involves the prescription so there's real room to benefit from the HIT.

And I'm thinking also about what it could do to help the providers. We struggled a lot with this visit, lost the follow-up, patient reminders and EHRs and health information exchange can help with that in a dramatic way.

So this setting is really right to reap the benefits of meaningful use of EHRs and health information exchange.

And this slide is really, I'm not going to go through it but it's meant to show you how much better each of these steps within most women's clinical spectrum. And this is obviously not a comprehensive list of most women's clinical spectrum. But how some of the information that's in an EHR would be so helpful to move within this cycle so knowing their readiness and their self-efficacy issues, knowing whether a pregnancy was unplanned or mistimed, knowing what the timing of the entry was into prenatal care, what the risk behaviors are.

I mean how often does family planning providers know what the discharge instructions were when the patient came out of the hospital, not very often unless the patient recounts it.

What the parity is? All of these things would help reinforce optimal care in all of these settings and all of this could be enabled through an EHR and health information exchange.

So this is the timeline. I'll leave this for you all to look at at another time. But we wanted to make sure people were aware of these key dates.

And next steps and resources, on this slide is the CMS web site. We have a lot of tip sheets for eligibility issues and what's meaningful use, PowerPoints that you can download. We have searchable frequently asked questions. Lots of information, the state Medicaid agencies should all have something on their web sites now or shortly and a designated email address.

The CMS Regional Offices which are located at the same place as the general HHS Regional Offices that you already work with, they all have a designated person to deal with the questions around the EHR Incentive Programs both Medicare and Medicaid.

And then I threw myself and my colleague (Michelle)'s emails up here because we're more than willing to answer questions as needed as well.

And with that I'll stop and pass it to Joy because we're going to do questions at the end.

Joy Pritts: Thank you. Can everybody hear me? Am I on mute?

Jessica Kahn: No, we hear you.

Joy Pritts: Okay, great. All right, I've been asked to speak with you about how we're going to ensure privacy in the electronic health information exchange.

And it's a good question. We're going to start this discussion with looking back to HITECH which is what created these great incentives for adopting health information exchange and the electronic healthcare records.

In HITECH as Jessica mentioned our office, the Office of the National Coordinator was created. And one of the charges that our office has is to

coordinate and inspire the development of a nationwide health information infrastructure with the goals of fixing our broken healthcare system. Wouldn't we all like to see that?

Including improving the quality of care, promoting preventive care, reducing cost, providing medical decision support, facilitating research, reducing disparities; there are a number of other charges there but all of this is supposed to occur within a secure and protected manner.

HITECH as Jessica's explained it does not mandate the use of electronic health records or electronic health information exchange. But it does create the final financial incentives to adopt a meaningful use EHRs, and to engage in electronic health information exchange electronically.

One of the essential components of this of course is adopting an electronic health record.

And what is an electronic health record?

Well a lot of people have used electronic systems in the past for billing purposes and for appointment purposes.

But an electronic health record goes beyond that. It focuses on collecting and collating clinical data. Now a lot of people view this as being the electronic medical record. And it is. But it's a lot more. It also should have decision support, perhaps scheduling capabilities, provides for exchanging health information with other providers, will facilitate the communication with patients including things such - so important as notifying test results.

Now some of the electronic health records we will talk about just a little bit is that is that it's not - the functions of these and what a record has to do is one of the things that is required of ONC.

So there are two parts of this at least but two large parts. CMS is setting the standards under which they set the rules for how physicians can receive payment from meaningfully using electronic health records. And ONC is setting the requirements for what makes an electronic health record qualify.

So our office is working very closely with CMS on doing this so that when providers - to ensure that the providers adopt a technology that will facilitate all these goals that we've been talking about.

One of the - we have a number of programs here in ONC in addition to this certification program for the electronic health records. And some of them are more familiar to you than others.

We have as part of our charge looking at this nationwide health information infrastructure. It has been called the Nationwide Health Information Network within our office which is developing standards, identifying standards that can be used to share this information, policies, conducting demonstration projects.

We also have the Regional Extension Centers which are - Matt will talk about today which are reaching out to the individual providers to help get them onboard with electronic health records.

We're also giving grants for HIT training and to Beacon Communities which are cutting edge communities that we can look to to see some of the really advanced ways of sharing this information and using it to advance healthcare.

We also have the State Health Information Exchange Cooperative Agreements. And those agreements are intended to assist the states in facilitating and accelerating health information exchange within that region. I'm pulling this one out in particular because I think this is very important for all providers to recognize that this effort is taking place on what I would call a dual track.

We're getting the providers to adopt the EHRs at their level and we are also setting up the mechanism, helping the states set up the mechanism so that they can - they will be able to meet the meaningful use goals by being able to share some health information electronically but also on a much broader scope just being able to exchange electronic health information for care purposes.

Now in doing this we awarded I think it was over $.5 billion worth of cooperative agreements to the states and so every state is participating. And they are taking different approaches as to how they're going to be exchanging health information within the state.

And there, again there are two components of this. One of these components is how are - what kind of models are the individual providers going to be using to share - store the health information locally. Like what kind of an EH model are they going to have.

And there are a number of different ways though, that providers can do this. They can have a server in their office.

They can use what we are now calling a Health Information Service Provider. You probably used to hear at least some of these similar entities called HIOs, Health Information Organizations. Some of those have a central repository where they share - they store the data on behalf of the individual providers.

And others have more of a federated or distributed system where the health information stays primarily at the local - the point of service and then it is called upon on an as needed basis.

The lines between these models get very fuzzy as to where the information is maybe stored including those in the, you know, what we like to call in the cloud which are remote commercial servers.

So it's not - it's a little different, in some ways analogous to where people share those - store their records today. And some people keep their records in paper files in their offices. And other people keep their files primarily at some other centralized offsite data storage center except for the ones that they're using right now.

In addition to these different models for storing the information as the states move along there are different models for sharing the health information. And this is more where the state HIEs come into play and they're developing different models for how to do this, and a lot of this based on local need and local, you know, belief as to how information should be held.

And they - one method of sharing information is what we call "A push" where the transfer of the information is initiated by the provider who's holding it. And they send it to another provider.

And a clear example of this would be ePrescribing where a doctor or a provider transmits electronically a prescription to a pharmacist for filling. And that is something that that provider knows. They're sending out that information and they should know exactly who that's going to.

Another model for electronic health information exchange is what we call query response.

And in that this is often used with the distributed model where there's a record locator service. And in this model what happens is a provider may be seeing a patient and saying, "Gee, I don't have very much information on this patient. I'd really like to know more about this patient."

And they send out an inquiry through the system of participants and say, "Do you have any information on this patient?"

And they get a list back of providers who might have information on that patient. And then and they can request that information. And then the provider who holds the information actually furnishes it.

And it happens, it sounds like a tedious process, but it happens almost instantaneously.

None of these are really clear models in the sense that anybody does just one of these things really. For the most part there are hybrids developing where people engage in all of this type of activity. And this is what - where you'll be seeing - what you'll be seeing as you go forward.

All of these models present challenges for privacy. And you have to - you're wondering probably well it sounds like the information is flowing a lot of different places. It sounds in some of these models like it's no longer held by the provider. It's resting with a third party.

How is this information going to be protected?

And I know that you are all well aware of HIPAA having had worked with it for a number of years. And HIPAA continues to apply. It applies to most healthcare providers who would be participating in these systems. If they were a healthcare provider covered by HIPAA before, there's nothing that has changed.

What has changed is that these third parties, some of these third parties who hold information directly on behalf of a healthcare provider are now expressly considered business associates under HIPAA. And they are directly subject to regulation by HHS under HIPAA. And both of those changes took place under the HITECH Act.

What that means is that when the - when Congress was putting all of this expansion of health information exchange into play they recognized that they also to expand the privacy protections along with it.

These privacy protections as you all know have detailed provisions on the use and disclosure of protected health information. And, you know, at a federal level it pretty much treats all health information the same except separately maintained psychotherapy notes.

HIPAA also permits the disclosure without the patient permission for treatment, payment and healthcare operations. The minimum necessary rule does not apply to request for a disclosure of information for treatment purposes.

And this is one of these top two issues I'll talk about it a little bit more but these are two of the issues that have really come up repeatedly as demanding additional attention as we move into an electronic world.

Do these rules still make sense when you're exchanging information the way that we're talking about?

And that is a question that's being addressed at a policy level by a number of (unintelligible).

HIPAA also permits disclosure for judicial or administrative proceedings as you all know and for law enforcement.

And in the family planning area I think a lot of you are aware that this has proved problematic in the past where there have been kind of searches and particularly in the Midwest of people who are a little bit shall we say over zealous focusing on family planning clinics to obtain information on what activities they're engaging in under the guides of subpoenas and administrative requests.

These are also things that at least important to think about how this is going to play out in an electronic health record environment.

Will it be easier?

Will it be harder?

The rule doesn't changed but often this information is protected at the local clinic level because there is somebody who is in place who's well trained in confidentiality and knows when to say no.

And if the information is being held by a third party the question is are they equally well trained. It's not a question that we have an answer to right now.

Some new aspects of HIPAA that were put into effect by HITECH include the fact that now patients are allowed to restrict the disclosure of - to health plans information related to treatment that they paid out of pocket directly.

And HITECH also expands the accounting of disclosures which is a right a patient has to find out who their information has been sent to, to include disclosures made for treatment, payment and healthcare operations purposes. That's a broader purpose than before. This might have some implications for information which in particular which is related to minors' health information because it will be - the accounting might inadvertently disclose some - the transfer of information that would reveal where the minor was receiving treatment.

I'm sure you're also all familiar with the fact that the HIPAA privacy rule is a floor. It is not a ceiling. It does not receive more stringent state and federal law. Many of these laws which require patient consent to share information where HIPAA would not. Of course including Title X, 42 CFR Part 2 which is a federal substance abuse confidentiality regulation, some other examples include state HIV test-related laws or mental health laws.

As you know Title X requires that the individual provide their permission, their written consent for most exchanges of information. And this is very similar to the kind of paradigm that sets up from these other laws that protect sensitive health information. Most of them require a patient consent in order to share the information that is deemed "Sensitive."

And in fact 42 CFR Part 2 is even more stringent than Title X. And it requires consent. It also specifies that it cannot even reveal - information shared cannot even reveal the person as potentially having been treated for a substance abuse condition.

And it says it restricts the recipient's re-disclosure of the information. So for example if a patient agrees that their information can be sent onto another provider that second provider also cannot share that information unless they obtain the individual's permission.

These laws have presented some implementation challenges. Frankly I think we all know that the easiest way when you're dealing with health information particularly in an electronic environment the easiest way to share it is just to share all of it. But that's really not a good idea just from a policy perspective and it is not a good idea from a legal perspective more importantly.

But what it does mean is that we have to figure out ways to manage these consent forms and figure out how we're going to consent and how we can record them and implement them electronically.

Another major issue that sensitive information and, you know, it's not just sensitive information that we designated as such under law. This issue comes up a lot of times by any healthcare patients where they say, "Well look, I don't want to share all my health information with just everybody I go to. It's none of their business."

So what it is is that a lot of people would like to see the ability to exchange some but not all of their health information through an electronic health record. And this is what we call data segmentation. There is a directive in HITECH that our office examined technology to facilitate this type of protective model.

And I will talk to you in a minute about how we have done that.

One of the implementation challenges that we've heard a lot of - about has been in the minor's area. And I know that a lot of minors get their health treatment in Title X facilities.

And how does one when minors have - in different states minors are able to consent to treatment. And in many states when a minor consents to treatment then they also control the access to that information.

So in some circumstances a minor can control health information. And in other circumstances it's the parent that does such as, you know, when a minor just is getting regular treatment from a regular healthcare provider that information is controlled generally by the parent until the minor gets to be 18.

So as you're - as these records are being exchanged and being shared with others it's going to be a challenge to know which information can be shared and which can't be which the minor controls and which the parent controls and how we are going to be able to do this electronically.

It raises a lot of questions too. Are there gaps? Is HIPAA enough? These are questions that we hear and when we hear about how we have these potentials because under HIPAA of course the exchanging health information for treatment, payment and healthcare operations requires no patient permission.

And so when you move to electronically some are raising the question is whether this is enough given the way that these systems are developing.

Well some of the - those issues are being addressed and raised in the Health Information Technology Policy Committee Privacy and Security Tiger Team Work Group. They worked over the summer and they have issued some preliminary recommendations on when additional consent beyond that

provided in HIPAA should be required for exchanging patient health information electronically through these systems.

In addition to that we have been working on identifying and sharing best practices because some of those implementation challenges that I just identified people are already working on those. Some large health plan systems have already been addressing, how do you address for example minor's data when you're dealing across state lines?

We're also doing a lot of work developing standards for consent management and for protecting sensitive health information. And as I said we have begun investigating the technology fro these purposes.

And we had a Technology Conference. It was a Technology Hearing this summer where we had people who have implemented some ways of protecting health information to demonstrate what they were doing.

And we have that information available on our web site.

What our goal is to assure that as we move forward that privacy and security remains central elements of health information protection both at the EHR level and at the health information exchange level. We want to meet patient expectations. People have certain preconceived notions of how their information should be shared. They believe it's very personal to them. And it is. And there should be no surprises.

What also I think is important to keep in mind that the technology should not drive the policy decisions. If we let current technology totally drive this we would be limited in how we can potentially address privacy issues.

So the only way to get people to move forward and to really move these things into an electronic format is to push the technology forward.

A perfect example of that is paper consent. I just can't see that in 15 years we're still going to have people signing paper consents and storing them in paper and then creating a PDF and sharing them that way. So we need to be thinking forward.

What I would like to encourage you to do in thinking forward and in moving on these issues is to get involved to the extent that you can with the State Health Information Exchange Projects. They are working on state models for how state - how information will be exchanged.

And privacy and security are essential components of that. And they - in developing their systems stakeholders are to be involved and it's important that everybody's voice is heard at these tables.

So we will be providing a list of this - of the state HIE awardee contacts. I believe it should be available on the web site in December.

And thank you very much. And I'll turn it over to Matt.

Matt Kendall: Thanks Joy. And it is a true pleasure to be on this call especially to have both (Jess) and Joy who have given great background about both the EHR Incentive Program and all the work we're doing really around privacy, security and to establish trust.

What I'm going to talk about now is a little bit about the Regional Extension Center Program. And how we're here and the work that my team is doing

really to help providers such as the folks on this call implement electronic health records and ultimately achieve meaningful use.

And, you know, it's worth a little background. I used to run a federally qualified health center in San Jose, California. And, you know, we did some Title X work and we worked very closely with a lot of other folks in our area who did.

So I know a lot of the challenges that you folks are thinking about when they're contemplating moving forward with electronic health records system. And I want to say that, you know, that there are great resources available to you.

And the focus of my team is really to help you go through what is often a very challenging but very rewarding decision as you go forward.

So really a little quick background, you know, we've already talked a little bit about it but the Office of the National Coordinator is really focused on helping with health information technology across the country. We're doing all kinds of different things around this trying to leverage the different work that's happening in different places.

And I think that the real interesting thing is in the last year we've really changed from being sort of a policy shop really thinking about ways in which we can really begin providing grant assistance and expanding our efforts. And, you know, this is sort of the framework at our whole office.

And what I should note is that, you know, we have a variety of new programs that have been implemented in the last year.

My office, the Office of Provider Adoption Support or OPAS, the Office of State and Community Health Programs, you know, a lot of our grant programs really have just begun going in the last year. So we're still in the very early stages of rolling out stuff that we hope will be very useful and supportive across the board.

So getting into what my team does. You know our real focus here is to help providers to get meaningful use of the EHR systems. And we have a whole variety of programs that we're developing to sort of support that. And I'm going to touch upon each one very quickly.

But I know we're running out of time and I want to make sure we had some time for questions so I'm going to go through this fast.

But the whole concept of what we're trying to do is to provide support to the various aspects of what you need to be thinking about whether it's through programs like the Regional Extension Center or just advising services like our team that's working on provider adoption services for meaningful use.

But the whole idea of what we're doing is trying to leverage all the different resources that are out there and get them in a way that is acceptable to providers as they move forward.

And again, you know, one of the things that I think Jessica did a really good job of her slides talking about why people should take on implementing EHRs and it really is a - it's a big challenge. But there are a lot of different reasons why you should be doing it.

And I think that there are a lot of different benefits that people can think about as we go forward. And people who've gone through it really do - it is worth that pain but it's a huge challenge.

So what we're trying to do with the Regional Extension Centers is give folks one location where they can go to get any questions they have answered about sort of, you know, meaningful use or more importantly, you know, get the support and resources that they need to begin the process of adopting an EHR.

And, you know, our goal is to try to start looking at primary care providers across the country and in a short amount of time get a large number of those folks to meaningful use.

But this is just the beginning point. I think the Regional Extension Centers are really trying to be a great resource for the community.

And if there's one message I could have for folks on this call is that you should definitely reach out to the local Regional Extension Center and find out what exactly they're doing because they're really designed to be providing services that are tailored to the needs of local community.

And again, you know, our goal is to have folks across the country. And we actually did - by the time when I submitted these slides and today we've actually announced the last of our Regional Extension Centers so we have two more so we now have 62% - 62 Regional Extension Centers and we have 100% of the country covered.

And again we're really focusing on, you know, providers who historically really haven't had the resources to do this on their own.

And we're looking to bring together people and bring together the resources and use a common use of scale to really help people get better deals in terms of EHR implementation, learn best practices and also make sure that we're really working in different settings.

We're very active with community health centers, world health centers, public hospitals, critical access hospitals. Title X providers really sort of get in this area and we have a lot of our Regional Extension Centers that have extensive work that they're already doing with Title X providers.

So this is sort of a map of the current Regional Extension Centers. And again it doesn't have the last two. The last two are in Orange County and New Hampshire.

But again appropriate to this is to really illustrate that they're - everywhere across the country there is a Regional Extension Center.

And again they're really trying to figure out how they can help the needs of the providers in their community. This is a list.

But the best place to find out about them is to really go to our web site. And I have that link in a second.

But the type of services the Regional Extension Centers are providing vary by local market but there are certain core things that they're all doing. They're all helping with vendor selection and implementation support. Helping providers understand what they need to do to implement, how to set up the different systems. To think about all the key questions that you need to be getting so that there are no surprises in the implementation.

They're providing a variety of different types of program management assistance from templates, best practices to actually onsite support. And really helping practices focus on workflow redesign.

And I got to emphasize that this is very, very important because if you don't think about how you can use the technology to really support your processes you can run into a lot of problems.

And spending that amount of time in the beginning, thinking things through, developing the right approaches really is a critical element for long term success.

And also the Extension Centers are working with other folks in their area to try to help find talent to help implement these systems because we recognize that this is a new technology that's been in place. A lot of organizations just don't have people who are familiar with this and they need to find new staff or get their existing staff resources as well.

And what we're trying to do is to leverage the knowledge and support of all the programs across the country to identify best practices. So we're using a process called (community) practice where we're getting the Regional Extension Centers together and saying hey you have this population such as rural health providers. How can we provide Special Ed. services to really address the specific needs?

And again I think the goal here is not only to help get all the providers across the country to meaningful use ultimately. But also to make sure that we're really addressing specific needs of groups.

And I think Title X providers really do fit in that area. And there's a lot of best practices that can already be identified and shared among folks who are beginning to contemplate the transition.

I thought I'd give one concrete example of Extension Center just to give you guys a sense of what exactly we're talking about.

So the example I'm going to give is the Regional Extension Center that was developed for Chicago. And it is the Chicago Health Information Technology Regional Extension Center.

And really its goal is that it's a partnership between the Alliance of Chicago which is the Health Community - Health Controlled Center Network or HCCN, funded by HRSA and in partnership with Northwestern University.

And these two entities got together to try to come up with a strategy to help all the providers in Chicago get to meaningful use.

And they're - right now they're starting off by just focusing on, you know, the providers, about 1600 providers but their mission is much broader.

And they're trying to think about ways in which you can use technology not just for technology sake but to do things like improving patient's quality and safety, reducing health disparities, engaging patients in their families.

And I think it's very important to think about that, those larger goals when you're implementing these systems. And having an organization like a Regional and Health Extension Center that can sort of help show the potential of technology I think is a very important tool in different communities.

The organization's doing a variety of things. They're working with their FQHCs and community health centers and signing folks out - they're doing surveys. They're trying to look at actually how folks are actually using the technology and making sure it works together.

And I think part of what their strength in the system is to make sure the people in the area are talking to each other, talking about how things are going, different tricks, learning from it because implementing a system can be a very lonely experience sometimes. People feel like this is they're reinventing the wheel often.

So by creating sort of a local network where people can tap into each other's expertise and knowledge, they're finding to be a very powerful, powerful resource.

And also it's helping in thinking through how they're doing workflow redesign.

So an important thought about workflow redesign that's coming out of the Chicago group is that it's really an iterative process that needs to be done over and over again. But it can build on each other.

And they've been developing some great tools about how we can think about that and we'll be sharing those with Regional Extension Centers and providers that are interested.

You know and again there's a lot of things that what - you know, working with the Regional Extension Center, that there are a lot of reasons to do it.

And the first and I think most important thing is this is just hard stuff. And that the Extension Centers are there to help.

They're also using economies of scale so what they can do is get better deals to reduce costs and figure out more comprehensive strategies.

And finally they're also trying to work with other resources like hospitals, to think of ways of developing interfaces and address issues like privacy and security on a local level to make sure that information is used to its best possible ability.

And I think that they are really a great resource for our folks across the country to think about and taking advantage of.

So again the best way to find out about what's happening in your area is through our web site. And there's a link right up here but if people go there you can get the most updated list of the Regional Extension Centers and links that can take you directly to them.

And again I would suggest that everybody on this call who's even thinking about this, call the Regional Extension Center. Find out how they can help you and how they can work with you because you are certainly one of the priority populations that they're working for and, you know, they may be calling you soon as well. So if they do this is a little background about what they're doing.

And that is it. So I guess it's now time for questions.

Marilyn Keefe: Hi. Thank you so much to our three speakers. That was an incredibly comprehensive presentation of information that I know people are going to want to go back to.

And just a reminder that this is going to be posted on our web site, probably it will take about three to four business days.

But we can go back and everyone can consult that information when they need to.

So I think without further ado we just want to move to questions.

(Angela) are you ready?

Coordinator: Yes. Thank you. We will now begin the question and answer session. If you'd like to ask a question, please press star 1. Please record your name. Your name is required to introduce your question. To withdraw your question you may press star 2. Once again if you'd like to ask a question, please press star 1. One moment please, while we wait for the first question. First question comes from (Sheldon Barr).

(Sheldon Barr): Hi. Yes, I'd like to know whether OPA is in any way looking at making funds available through Title X for those clinics and Title X supported programs that don't qualify either as an institution, a provider or under the Medicaid rules.

Marilyn Keefe: This is Marilyn. I - we don't have a good answer to that question at the moment. We're certainly looking into informational presentations like the one we've had today.

I wish I could say that there'd be a big boost in Title X funding in the coming year but we don't really anticipate that. We'll be talking some more to see if there are some other ways of assistance that we can give to clinics.

In terms of sort of large grants to people to actually purchase electronic data systems, I can't promise that.

(Sheldon Barr): I see. Thank you.

Coordinator: Next question comes from (Steven Grubis).

(Steven Grubis): Hi. Can you hear me?

Marilyn Keefe: Yes, we can hear you.

(Steven Grubis): Oh, where can I get a listing of certified EHRs?

Matt Kendall: I'll take that one. We will be posting a list of the certified EHRs on the web and you can get that information by going to the ONC web site. They're still in the early stages of processing that information and getting those lists together. You can also contact a Regional Extension Center and they should have that information as well.

(Steven Grubis): Okay, thanks.

Coordinator: Next question comes from (Sherry Bonner).

(Sherry Bonner): Hi. I'm wondering when you will start issuing the incentive checks or when they will be issued in calendar year 2011.

Jessica Kahn: You mean the incentive payments?

(Sherry Bonner): Yes, the incentive payments for providers.

Jessica Kahn: Sure. So this is (Jess) so for - I'm sorry if there's background noise. I'm shamelessly on the phone in my car.

So for Medicare the plan is to start actually making the payments in May. So providers can register in January. They will accept attestations in April. And we'll start to see payments coming out in May.

For Medicaid however for those states that are going to launch their programs in January and there are currently 18 states that believe they're going to be ready to do so they believe that they will be able to start making payments sooner, perhaps February.

And the reason for that again is because under Medicare when a provider registers then they have to spend 90 days demonstrating meaningful use in that calendar year whereas for Medicaid adopt, implement and upgrade does not have an EHR reporting period. So someone could register and attest all on the same day and theoretically then the state could process the payment.

So those states are telling us January, late January, February for the first Medicaid payment in their states.

(Sherry Bonner): Thank you.

Coordinator: I show no further questions.

Marilyn Keefe: Well thank you everyone for participating. And thank you to the speakers. This was an incredibly informative presentation.

Jessica Kahn: You're very welcome. Thanks for inviting us.

Marilyn Keefe: Thanks.

Joy Pritts: Thanks for having us. Bye.

Marilyn Keefe: Good afternoon.

Jessica Kahn: Bye.

Coordinator: That concludes today's conference. Please disconnect at this time.

END