

ANIA-CARING is a nursing informatics organization advancing the delivery of quality healthcare through the integration of informatics in practice, education, administration, and research.

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Differences in the CMS Medicare and Medicaid EHR Incentive Programs

Robin Raiford, RN-BC, CPHIMS, FHIMSS | Executive Director, Federal Affairs, Allscripts

With Meaningful Use and implementations of electronic health records (EHRs) across the nation, now more than ever before, it is important to understand how the legislation that was signed into law drove changes in regulation in the Centers for Medicare and Medicaid Services (CMS). The American Recovery and Reinvestment Act (2009) drove the creation of the CMS EHR Incentive Program. This legislation contains over 1000 references and language changes to the Social Security Act (1965) and Medicare Modernization Act (2003). The programs are showing great success to date since launching on Jan 3, 2011:

- 21,000 registered participants for the Meaningful Use program in January with thousands more in February.
- The total Medicaid incentive payments distributed by mid-February are \$1.6 million to Eligible Professionals and \$28 million to Eligible Hospitals.

The original language of who is eligible to receive incentives under Medicare is in the Medicare Modernization Act. Specifically, it describes who can receive EHR Incentives as a “physician” as defined in the Social Security Act. The figure below shows what legislation drove the subsequent CMS regulation, going all the way back to the signing of the Social Security Act (1965) which led to the creation of Medicare and Medicaid.

LEGISLATION	CREATED CMS REGULATIONS and INCENTIVES
1965 Social Security Act	<ul style="list-style-type: none"> • Medicare and Medicaid <i>definition of Physician</i>
2003 Medicare Modernization Act	<ul style="list-style-type: none"> • Medicare Incentive <i>who can get incentives</i>
2005 Deficit Reduction Act	<ul style="list-style-type: none"> • Inpatient Perspective Payment System (Medicare incentives for Quality Outcomes) and NO PAY events
2008 Medicare Improvements for Providers and Patients Act	<ul style="list-style-type: none"> • ePrescribing Incentives
2009 American Recovery and Reinvestment Act	<ul style="list-style-type: none"> • Electronic Health Record Incentive Program; • Health Information Technology: Initial Set of Standards, Implementation Specifications, and Certification Criteria for Electronic Health Record Technology
2010 The Affordable Care Act	<ul style="list-style-type: none"> • TBD- Payment Reform, Bundled Payments, Accountable Care Organization, Quality not Volume Focus

The incentives have started flowing in the Medicaid EHR Incentive Program and will soon start flowing in the Medicare EHR Incentive Program. It is important to note there are significant differences in the two EHR incentive programs. Legislative language in previous laws prevented CMS from including



By Susan K Newbold,
PhD RN-BC FAAN FHIMSS

ANIA-CARING MEMBERSHIP PROFILE

As of 03/01/2011, there are 2166 members from 50 states and 32 countries: Afghanistan, Australia, Bermuda, Brazil, Canada, Chile, Croatia, England, Finland, Germany, India, Ireland, Israel, Jordan, Kuwait, Lebanon, Malaysia, New Zealand, Pakistan, Panama, Philippines, Qatar, Saudi Arabia, Singapore, Slovenia, South Africa, South Korea, Spain, Taiwan, Thailand, UAE, USA.

GRADUATION DOCTOR OF NURSING PRACTICE (DNP)

Rebecca B. Shaheen, Murrysville, PA, DNP from Waynesburg University in December 2009. Dr. Shaheen was in the first DNP graduating class.

GRADUATION MASTER OF SCIENCE IN NURSING (MSN)

Julius A. Saisi, Lenexa, KS earned her MBA in healthcare management from Avila University School of Business, Kansas City, MO and her MSN in healthcare informatics from The University of Kansas School of Nursing August 2010.

Madhavi (Madi) Nayar, Altadena, CA, received an MSN in Nursing Administration from California State University, Los Angeles, in December of 2009 .

CERTIFICATION IN NURSING INFORMATICS FROM THE AMERICAN NURSES CREDENTIALING CENTER (ANCC):

Lisa Popovnak, Johnson, PA, was certified in NI 09/10/2010.

Carol Williams, West Chicago, IL was certified in NI January 3, 2011.

Differences in the CMS Medicare and Medicaid EHR Incentive Programs

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Nurse Practitioners, Certified Nurse Midwives, and Physicians Assistants in the Medicare EHR incentive programs, and they can only apply for Medicaid EHR Incentives. This same situation happened to Long Term Post-Acute Care Organizations, Rehabilitation Hospitals, Psychiatric Hospitals and Cancer Treatment Centers. Hospitals eligible for the Medicare EHR Incentive Program have to be paid under the Inpatient Prospective Payment System also as defined in the Medicare Modernization Act (2003) and the Deficit Reduction Act (2005).

Comments are frequently made at the (health information technology) HIT Policy Committee meetings that advanced practice nurses should also be eligible for Medicare EHR Incentives. The comments are received, and the commenter thanked, but there is a problem -the comments need to be directed to the source that has to power to fix that issue. That means that the comment needs to be directed to members of Congress. Until the law is changed, CMS does not have authority to change something that is actually in one of the laws. CMS regulations must follow the mandates in the applicable laws. So if you see a message posted to the ANIA-CARING list and a link to “tell your congress representative” – SPEAK UP! – Follow the link!– this is your opportunity to be heard. Advocacy tools make it very easy to submit input to your member of Congress.

The other differences in the Medicare and Medicaid EHR incentive programs are summarized in the table below. Once again, with the Medicaid EHR Incentive Program, CMS and the Secretary of Health and Human Services had flexibility to add features to EHR Medicaid program that the program did not allow Medicare because it falls under mandates from the Medicaid Modernization Act.

Medicare vs. Medicaid in ARRA

Details From CMS Final Rule	Medicare	Medicaid
Implementation Requirement	- Feds will implement - Option nationally	- Voluntary for States to implement - May not be an option in every State
Fee Reductions for Non-Meaningful Users	2015	No Medicaid fee schedule reductions
Meaningful Use Requirements	1 year except payment year ONE only will be 90 consecutive days	Adopt/Implement/Upgrade option for 1st participation year
Maximum Incentive for Eligible Professionals	\$44,000	\$63,750
Last Year to Initiate Program (EP)	2014	2016
Last Payment in Program	2016	2021
Professionals Eligible for Incentives	Only physicians as defined in Social Security Act Doctor of Medicine (MD) Doctor of Osteopathy (DO) Doctor of Podiatric Medicine (DPM) Doctor of Chiropractic (DC) Doctor of Optometry (OD) Doctor of Dental Surgery (DDS)	5 types of Eligible Professionals (1) A physician (2) A dentist (3) A certified nurse-midwife (4) A nurse practitioner (5) A physician assistant practicing in a Federally Qualified Health Center or Rural Health Clinic, which is so led by a physician assistant
Hospitals Eligible for Incentives	Subsection (d) Hospitals (hospitals that are part of the Inpatient Prospective Payment System) and Critical Access Hospitals	4 types of Hospitals Acute Care, Children's, Cancer and Critical Access Hospitals (new in Final Rule)

In addition to the type of eligible professionals that can apply for the two programs, fee reductions for non-Meaningful Users of an EHR will start in 2015 for Medicare only, not Medicaid. The maximum payment for Medicare program Eligible Professionals is \$44,000 over 5 payments and a total of \$63,750 over 6 payments for Medicaid Program Eligible Professionals. The Medicaid EHR Incentive Program continues until 2021, but only until 2016 for the Medicare EHR Incentive Program. The Medicaid EHR Incentive Program does have a Medicaid encounter volume requirement of 20%-30% to be eligible, but there is also the very big difference that the Medicaid EHR Incentive Program allows for

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Differences in the CMS Medicare and Medicaid EHR Incentive Programs

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the first payment year to be in the process of “adopt, implement, and upgrade” of certified EHR technology. The Medicare EHR Incentive Program starts with the requirement of “Meaningful Use” of the certified EHR technology.

During this exciting and challenging time in our country, we have the opportunity to reform health care and to improve the quality of healthcare delivered in this country. Perhaps one of the most important actions you can do for your profession and your patients is to let your Congressional Representative know your opinion, because once it is in the law, it is in the law and no regulation can change the law. Let your voice be heard!

Welcome From the Editor and Secretary

Denise Tyler, MSN/MBA, RN-BC

I would like to take this opportunity to thank Robin Raiford for her contribution to our newsletter this quarter. Any of you who have heard Robin, or read her postings on meaningful use and other government initiatives know that she has a gift of taking these complicated (and often dry) topics and bringing them to life and helping them to make sense.

I hope you enjoy the pictures (courtesy of Susan Newbold) from our networking event in Los Angeles this January. One of the top requests of members who responded to our survey last year was networking. Our regional directors, Patrick Shannon, Stephen Prouse, Brian Norris, and Vicki Vallejos have been busy working with members in their regions to coordinate events to promote networking and education. Speaking of education, the webinar presented by Brenda Kulhanek was well received and extremely valuable. It is available for members to replay on the website.

I hope to see many of you at the annual conference in May. If you have ideas for the newsletter, please reach out to me at any time. I would love to hear from you, and encourage you to participate in the newsletter team and in publishing an article!

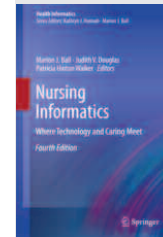


PRESENTATIONS:

Newbold, S. K. 24 January 2011. *AMIA NI-WG Nursing Informatics Pioneers History Project*. Belmont University. Nashville, TN.

PUBLICATIONS:

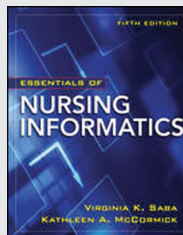
Many ANIA-CARING members have written for the following two books:



Ball, M. J., Dulong, D., Douglas, J.V., Gugerty, B., Hannah, K.J., Newbold, S.K., Sensmeier, J., Skiba, D., Hinton-Walker, P. & Troseth, M. (Eds.), (2010). *Nursing Informatics Where*

Technology and CARING Meet (4th Ed.). New York: Springer-Verlag.

Saba, V.K. and McCormick, K.A. (2011). *Essentials of Computers for Nurses: Informatics for the New Millennium, 5th Ed.*, New York: McGraw-Hill.



Bove, L. A., & Rossi, C. M. (2011). Implementing clinical systems with the future in mind. *Nursing Management*, 42(1), pp. 10-13.

Martin, K.S., Mosen, K.A., Bowles KH. (January/February 2011). The Omaha System and meaningful use: Applications for practice, education, and research. *CIN: Computers, Informatics, Nursing*, 29(1), 52-58.

Newbold, S.K., Franklin, TN. HIMSS Tennessee Chapter Newsletter (2011). *ANIA-CARING Spotlight*. Winter 2010-2011.

CONFERENCES:

7-9 April, 2011 Omaha System International Conference in Eagan, MN.

12-14 May, 2011, ANIA-CARING Annual Conference. Las Vegas Hilton, Las Vegas, NV.

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3-4 June, 2011, Nursing Informatics

Review Course, Nashville, TN,

Sponsored by MUSE,

<http://www.museweb.org>

20-23 July, 2011, Summer Institute in Nursing Informatics. Baltimore, MD. Look for the ANIA-CARING dinner Friday, July 22, 2011.

22-26 October, 2011 AMIA. Washington, DC. Joint AMIA NI-WG/ANIA-CARING get together Sunday evening, 23 October, 2011.

12-14 April, 2012 ANIA-CARING Annual Conference. Renaissance Orlando at SeaWorld®, Orlando, FL.

23-27 June, 2012, NI2012, Montreal CANADA, www.ni2012.org. Sponsored by the International Medical Informatics Association.

2-4 May, 2013, ANIA-CARING Annual Conference, Marriott Rivercenter, San Antonio, TX.

NI2015. Taipei, TAIWAN. Sponsored by the International Medical Informatics Association.

AWARDS AND HONORS:

Marion J. Ball, Baltimore, MD., was honored February 22, 2011 with the HIMSS 50 in 50 Award for Memorable Contributors throughout HIMSS' 50-Year History.

Daniel P. Boffa, Forest Park, IL, was certified in Med/Surgical Nursing by the Academy of Medical-Surgical Nurses (AMSN) in 2010.

Elizabeth "Liz" Johnson, Grapevine, TX., was selected for the HIMSS Nursing Informatics Leadership Award. Liz was presented with the honor at the Awards and Recognition Dinner, February 22, 2011 in Orlando, FL. In addition she was honored with the HIMSS 50 in 50 Award for Memorable Contributors throughout HIMSS' 50-Year History.

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Presidents Message: Meet Us in Las Vegas at the 2011 ANIA-CARING Annual Conference

Victoria Bradley DNP, RN, CPHIMS, FHIMSS, President, James J. Finley, MBA, RN-BC and Lisa Anne Bove, MSN, RN-BC, Conference Co-Chairs,

The annual ANIA-CARING conference, held each spring, is coming up soon – so please mark your calendars and plan to attend. This year's informatics conference is May 12 – 14, 2011 at the lovely Las Vegas Hilton and we hope you will be able to join us. This year's theme is "Nursing Informatics: Blazing the HIT Trail" and many of us already know that blazing the trail in HIT is fraught with perils. We invite you to attend this year's conference to learn from your peers and leaders as they share their exciting tales of what it takes to implement HIT successfully.

The conference speakers and program are finalized, and we are fortunate to have many leaders willing to share their adventures in HIT. Liz Johnson will share what is new with Meaningful Use as a member of the Federal HIT Standards Committee, and her saga of implementation across multiple Tenet facilities. Dr. Pam Cipriano will continue our journey by sharing the value of getting front line nurses onboard as partners to increase the likelihood of our achieving the benefits of HIT. And finally for the closing Barbara Wadsworth, a Chief Nursing Officer, will chronicle her journey to use HIT to transform care. Her active role in implementation will demonstrate the critical importance of senior leadership in any projects success.

The great thing about an adventure is meeting new people who are more than willing to share their strategies and skills from how to manage complex projects, overcome barriers, engage sponsors, convert laggards, measure benefits and much more. At last year's conference in Boston, 400 nurse informaticists attended – we anticipate attendance to be even greater this year.

Along the trail you will have the opportunity to earn up to almost 20 contact hours with educational sessions in five focus areas and 35 posters.

The pre-conference day on May 12 offers six half-day focused sessions – and this year we are pleased to be offering a special session presented by AORN looking at lessons learned with technology in the perioperative environment.

The regional reception on Thursday evening will provide time for networking with colleagues who share similar interests. This is the perfect time to pose your questions of "how did you?", over dessert, to gain new ideas and renewed enthusiasm for tackling the perils of blazing the HIT trail .

The ANIA-CARING board members will be present throughout the conference to seek feedback on how we are doing, what you would like more of and how you would like to contribute! An association update will be presented at Friday's membership luncheon.

You will again have access to more than 20 service and product providers in the Exhibit Hall where you can learn about their solutions. You can also use this opportunity to provide your feedback and share what additional products and solutions are needed.

You will have free time on Friday evening to enjoy the plethora of activities offered by Las Vegas, just don't forget to get enough sleep to enjoy another full day of education, exhibits and voting for the best poster on Saturday.

The Annual ANIA-CARING Conference promises to be one of the best meetings yet.

Take advantage of this unique opportunity to lead yourself and others to success by enhancing your skills and inspire passion for our fantastic profession of nursing informatics. Please join us and your colleagues in this opportunity to support you as a trailblazer in HIT.

The full conference brochure and program information along with on-line registration is available at our website, www.ania-caring.org.

Education: Plan, Do, Survive and Thrive

Denise D. Tyler, RN-BC, MSN/MBA

It takes many members of a hospital community to successfully provide education for a large-scale clinical system implementation. Education planning must start at the initiation of the project. Involving end users on design teams will provide valuable insight into what their peers will grasp quickly, and what they will struggle with. This perspective will help to develop the education plan by showing where to focus time and where to spend less time. Start noting their insights early because as the team spends more time in the system, their objectivity about some of this may decrease. Szydowski and Smith (2009) recommend extensive education that translates to budgeting early for it. If unsure of the time required for education during the budget process, then plan on the high side. It is better to overestimate the time required than to underestimate it and ending up over budget.

Identifying basic computer skills that are key to the users is also important when planning education. If the users are lacking in basic computing skills, they will need more assistance and time in the class to these basics before learning the application. One site required users to clock time playing solitaire in order to learn mouse skills, and used programs for improving keyboarding and mouse use in other areas. Clinical educators, managers, and super users may all have insight into staff that will need extra time to become more proficient in their basic computer skills. Terry et al. (2008) correlate users' computer experience with the success of the implementation.

Who will provide the education? Will it be the clinical Information Technology (IT) team, or the systems educators, or super users, the vendor or a combination? Every organization has a unique culture and language, so using non clinical IT staff, or consultants may be adequate for educating on the system, but not addressing changes in workflow or the clinical processes associated with the documentation system (McIntire & Clark, 2009). Using experts familiar with the current state, and who are able to communicate changes and improvements, will further improve the learning achieved (Dennis, Wixom, & Roth, 2009). While super users and end users may be familiar with unit processes and workflow, they may not be comfortable speaking in front of others or leading a class. One solution is using a combination of educators, consultants and super users (consisting of end users when possible because it provides users familiar with unit processes and staff who are comfortable teaching larger groups). Not all organizations include workflow or process changes, in which case those less familiar with unit processes may suffice. However, the implementation process is the perfect time to make changes to improve workflow and processes. It is not essential to a successful implementation, but not reassessing workflows for improvements is a missed opportunity.

Early identification of users to be trained and classrooms/computers available for training, is extremely important. It is essential to determine how many staff will be available to provide the education, whether attendance is mandatory, and how will it be tracked. Optimally, classes should be held as close as possible to the go-live event to enhance the retention of the new knowledge and skills learned (Dennis et al., 2009). Factors to consider when determining when to start education, and how long each class will be include:

- How many kinds of classes will need to be developed?
- How comfortable are staff using computers?
- Classrooms: how many computers are available for use in education? (Be creative in creating space!)

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Karen S. Martin, Omaha, NE, Health Care Consultant, Martin Associates, Omaha NE received the Ruth B. Freeman Award from the Public Health Nursing Section in November during the American Public Health Association Annual Meeting. Karen received the award for her distinguished career and accomplishments involving practice, administration, research, policy, and information technology. The focus of her career is the Omaha System, a standardized terminology designed to enhance practice, documentation, and information management.

During October 2010, Karen spent 15 days in Hong Kong and Mainland China as an Honorary Fellow and Visiting Professor at the Hong Kong Polytechnic University School of Nursing. She spoke about the Omaha System and conducted workshops at numerous locations.

BYTES OF INTEREST:

Michael C. O'Malley, Worthington, OH, would like to announce his recent name change (formerly Michael Gay). He is an 11 year member of ANIA-CARING.

Please send items for future newsletters to: Susan K. Newbold,
sknewbold@comcast.net

- What resources will be available and ready to provide education?

Understanding the organization's previous success with large volume training is important as well. Some organizations find it more efficient for managers to assign staff to classes, to ensure that staff are signed up for the appropriate class in a timely manner. Other organizations allow staff to sign-up and this can decrease the number of rescheduling requests due to outside conflicts of which the managers may not be aware. Either way, the process of signing up for education should be automated and user friendly for both staff and the project training team. The names and descriptions of the classes should clearly identify who should attend. Automating attendance tracking is best if at all possible to provide accurate and timely reporting to management. This can assist management in scheduling staff and the project team in identifying the need to schedule more classes if necessary.

Standardize the training material provided to the types of users, and combine types of users when possible to simplify scheduling and the development of education material. This may mean adjusting the flow of the class to allow people to leave in stages. For example, if some (but not all) unit secretaries also perform nurse aide duties cover the nurse aide functions at the end of class, allow the staff who do not perform these duties to leave early. Another example is, if nurses in specialty areas do not chart care plans then, cover this last and excuse these staff early. This can be a more cost effective and decrease some of the complexities of scheduling.

There are multiple applications, such as Captivate, that can be used to develop tutorials for use in class and

on-line by users. Walking through the tutorials in class is an excellent way to standardize what is taught, and decreases the stress of staff who are either not as comfortable providing education, or as familiar with the application. Follow each tutorial with hands-on practice is the best way to reinforce the material covered. Providing the tutorials and a test system to practice on after the class is completed will further reinforce what was learned.

Marketing needs to be done throughout the implementation process, including education. Management needs to understand that the executive team expects them to be involved and supportive. Class attendance should be held to the same standard as work: be on time and call ahead of time if you are sick and cannot make it! Increase management buy-in by involving them: ask them what their expectations are for the new system, and how it can improve their lives. Get input into what their priorities are for it. If the new system can provide improved auditing tools and improved staff compliance with charting expectations, use this as a selling point. Working with them to achieve these goals will increase their buy-in and support of the new system.

The system needs to be essentially frozen when education begins. Why essentially rather than absolutely? Education involves large volumes of staff, and no matter how many users were involved in the design, during education they will find things that are missing or need to be modified. Developing a list of changes and their priorities should be started now, if it has not already been developed. Having more users involved in the design and extensive testing will decrease the number of fixes and changes required later, but will not totally eliminate them.

What are the roles of the clinical educators and super users in the development of material and providing education? Will they attend extra or longer classes? Will they be expected to teach classes, or to assist with teaching? What is their current role in providing computer education and will it change after the new system is implemented? While not all super users will thrive or shine in teaching, they will all benefit from the increased exposure. Whether the clinical educators are directly involved in teaching the computer applications or not, they need to be involved in the design and understand the implication of the clinical system on the clinical staff. The organization's resources may change throughout the life cycle of the project. It may require adjustments in class scheduling and resources to meet the educational needs of the end users prior to and during the implementation. Good planning and wise utilization of resources can help minimize the need to make major modifications to the education and training.

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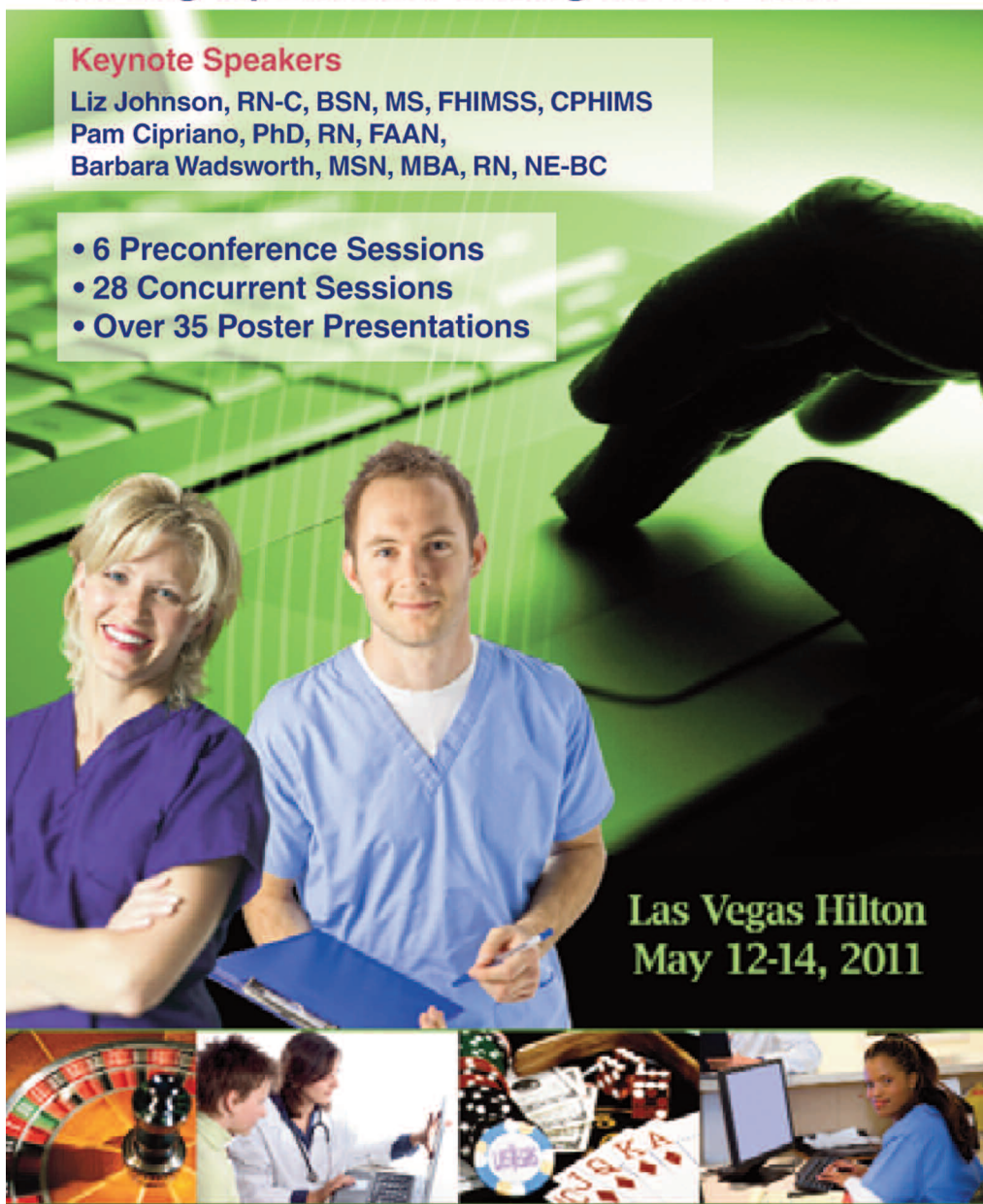
2011 Annual Conference

Nursing Informatics: Blazing the HIT Trail

Keynote Speakers

Liz Johnson, RN-C, BSN, MS, FHIMSS, CPHIMS
Pam Cipriano, PhD, RN, FAAN,
Barbara Wadsworth, MSN, MBA, RN, NE-BC

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Conference Brochure and Registration Information at
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