An Overview of HIT and Meaningful Use From A Federal Perspective

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Overview

- How did we get here?
- What is meaningful use and how does it differ between Medicare and Medicaid
- How does Meaningful Use Impact Rural?
- What can you expect in incentives?
- What do we need to do?

American Recovery and Reinvestment Act

- Enacted February 17, 2009
- Focused on jumpstarting the economy
- Nominally worth $787 Billion

What Funds Are Out There?

- Funds available from a number of Agencies
  - HRSA, AHRQ, CMS, NTIA, FCC, NIST
- ARRA has provided for funds to be distributed through above agencies and ONC
- Nothing is static

Summary of ARRA HIT Funding

- Total $19.2 Billion for HIT
  - $2 Billion for ONC
  - $17.2 Billion for incentives through Medicare and Medicaid Reimbursement systems
- Codifies ONC, HIT Standards Committee, HIT Policy
- Provides grant and loan programs to assist providers and consumers in adopting HIT
- Privacy and Security provisions in HIPAA for electronic health info

Summary of ARRA HIT Funding (CONT)

- $4.7 Billion for Broadband Technology (NTIA)
- $2.5 Billion for USDA Distance Learning, Telemedicine, Broadband Program
- $500 million to SSA
- $85 million for IHS
- $50 million for VA

What Are the HIT goals of ARRA?

- Give 70% of Americans an electronic health record (EHR) within 5-10 years.
- Use Medicare to incentivize the adoption of EHRs to improve quality, provide data portability, and allow for performance evaluation.
- Eventually penalize non-adopters by reducing reimbursement.
- Some rural providers will also be eligible for Medicaid incentives.

The American Reinvestment and Recovery Act (ARRA)

- Title VI- BROADBAND TECHNOLOGYOPPORTUNITIES PROGRAM
- TITLE IV—MEDICARE AND MEDICAIDHEALTH INFORMATION TECHNOLOGY;MISCELLANEOUS MEDICAREPROVISIONS
- TITLE XIII—HEALTH INFORMATION TECHNOLOGY

Title VI- BROADBAND TECHNOLOGYOPPORTUNITIES PROGRAM

- $4.7 Billion for Broadband Technology Opportunities Program: grants to States and other entities for acquiring equipment and other technologies related to providing broadband service infrastructure
- $2.5 Billion for broadband loans and loan guarantees. Recipients of these funds may not receive funds under the other program described above

Title VI- BROADBAND TECHNOLOGYOPPORTUNITIES PROGRAM

- Ensure that all funds are awarded by FY 2010
- Projects are to be completed within 2 years of award
- Eligible entities:
  - States (or political subdivision)
  - Nonprofits
  - Any other entity ruled by the Assistant Secretary of Commerce as acting in the public interest (broadband providers or infrastructure providers included

2009 RURAL UTILITIES SERVICE BROADBAND INVESTMENT PROGRAM

- ARRA requires that funds be obligated by September 30, 2010
- RUS will offer grants, direct loans and loan/grant combo.
- Funds will be awarded on a competitive basis
- Fund projects that will support rural economic development and job creation beyond the immediate construction and operations of the broadband facilities
- 75% of the investment serves rural areas
- Implement in concert with NTIA and FCC
- http://www.usda.gov/rus/telecom

Broadband

- RUS Broadband Initiatives Program (BIP)
  - BIP will make loans and grants for broadband infrastructure projects in rural areas
- NTIA Broadband Technology Opportunities Program (BTOP)
  - BTOP will provide grants to fund broadband infrastructure, public computer centers and sustainable broadband adoption projects
- http://www.broadbandusa.gov/index.htm

How Does This Affect Alabama?

List of awarded and pending Round 1 BTOP Sustainable Broadband Adoption, Public Computer Center, Middle Mile Infrastructure, and Last Mile infrastructure applications.

- ***Anniston Fiber Optics, Inc.*** **Last Mile** $5,097,508.00 Pending
- ***Deaf Action Center of Louisiana*** **Public Computer Center** $1,380,513.00 Awarded
- ***One Economy Corporation*** **Sustainable Broadband Adoption** $45,527,735 Pending

*as of March 3, 2010

TITLE XIII—HEALTH INFORMATION TECHNOLOGY

- ARRA provides $2,000,000,000 to the Office of the National Coordinator to carry out Title XIII until the funds are expended
  - Title XIII – Health Information Technology for Economic and Clinical Health Act (HITECH) – Inserted
- ARRA is required to direct $300,000,000 of the $2,000,000,000 to support regional or sub-national health information exchanges

Title XIII (Cont)

Four main focus areas:

- Public Health Information Exchange
- Health Professions
- Health Information Exchange
- Regional Extensions Centers

HIT Extension Centers

- The Extension Program will establish cooperative agreements through a competitive process to support an estimated 70 (or more) Regional Centers each serving a defined geographic area.
  - 32 RECs announced, with the remaining due soon
  - $643 million is devoted to the Regional Centers
- The Regional Centers will focus their most intensive technical assistance on clinicians (physicians, physician assistants, and nurse practitioners) furnishing primary-care services, with a particular emphasis on individual and small group practices.
- The HITECH Act clearly prioritizes access to health information technology for historically underserved and other special-needs populations, and use of that technology to achieve reduction in health disparities

Health Information Exchange

- Cooperative agreements have been and will be awarded through the **State Health Information Exchange Cooperative Agreement Program** to states and qualified State Designated Entities (SDEs) to develop and advance mechanisms for information sharing across the health care system.
  - 40 awards announce, with more forthcoming
- Under these State cooperative agreements $564 million will be awarded
- Program funds states' efforts to rapidly build capacity for exchanging health information across the health care system both within and across states.
- Awardees are responsible for increasing connectivity and enabling patient-centric information flow to improve the quality and efficiency of care.

Extension (Cont)

- The Regional Centers will support health care providers with direct, individualized and on-site technical assistance in:
  - Selecting a certified EHR product that offers best value for the providers' needs;
  - Achieving effective implementation of a certified EHR product;
  - Enhancing clinical and administrative workflows to optimally leverage an EHR system's potential to improve quality and value of care, including patient experience as well as outcome of care; and,
  - Observing and complying with applicable legal, regulatory, professional and ethical requirements to protect the integrity, privacy and security of patients' health information.

Eligibility

- For purposes of the Regional Centers cooperative agreements, a “primary-care provider” is any doctor of medicine or osteopathy, any nurse practitioner, nurse midwife, or physician assistant with prescriptive privileges in the locality where s/he practices, who is actively practicing one of the following specialties: family, internal, pediatric, or obstetrics and gynecology.
- The Regional Centers will give priority for intensive, individualized technical assistance to primary-care providers in individual and small-group practices, community and rural health centers, public and critical access hospitals, and other settings predominately serving uninsured, underinsured, or medically underserved patients

ONC Opportunities Pending Award

- **Beacon Community Cooperative Agreement Program**
  - **Objective:** This program will provide funding to communities to build and strengthen their health information technology (health IT) infrastructure and exchange capabilities to demonstrate the vision of meaningful health IT.
- **Curriculum Development Centers**
  - **Objective:** This funding opportunity, one component of the Health IT Workforce Program, will provide $10 million in grants to institutions of higher education (or consortia thereof) to support health information technology (health IT) curriculum development.
- **Community College Consortia to Educate Health Information Technology Professionals**
  - **Objective:** This program, one component of the Health IT Workforce Program, seeks to rapidly create health IT education and training programs at Community Colleges or expand existing programs. Community Colleges funded under this initiative will establish intensive, non-degree training programs that can be completed in six months or less.

ONC Opportunities Pending Award

- **Program of Assistance for University-Based Training**
  - **Objective:** The purpose of this program, one component of the Health IT Workforce Program, is to rapidly increase the availability of individuals qualified to serve in specific health information technology professional roles requiring university-level training.
- **Competency Examination for Individuals Completing Non-Degree Training**
  - **Objective:** This funding opportunity, one component of the Health IT Workforce Program, will provide $6 million in grants to an institution of higher education (or consortia thereof) to support the development and initial administration of a set of health IT competency examinations.
- **Strategic Health IT Advanced Research Projects (SHARP) Program**
  - **Objective:** The purpose of these awards is to fund research focused on achieving breakthrough advances to address well-documented problems that have impeded adoption: 1) Security of Health Information Technology; 2) Patient-Centered Cognitive Support; 3) Healthcare Application and Network Platform Architectures; and, 4) Secondary Use of EHR Data.

How Does This Affect Alabama?

- State HIE
  - Alabama Medicaid Agency
  - A portion of $386 M
- State REC
  - None awarded currently

TITLE IV—MEDICARE AND MEDICAID HEALTH INFORMATION TECHNOLOGY PROVISIONS

- Medicare Incentives both Provider and Hospital Based
- Medicaid Incentives to Providers, RHCs, FQHCs, and Hospitals
- Based on “Meaningful HIT Adoption”
- The Law established maximum annual incentive amounts and include Medicare penalties for failing to me meaningfully adopt EHRs
- Three broad criteria:1) Meaningful use of EHR, 2) Information Exchange, and 3) reporting on measures using EHR

EMR Adoption Model[SM]

		Urban	Rural
Stage 7	Medical record fully electronic; HCO able to contribute CCD as byproduct of EMR; Data warehousing in use	0.4%	0.0%
Stage 6	Physician documentation (structured templates), full CDSS (variance & compliance), full R-PACS	1.1%	0.0%
Stage 5	Closed loop medication administration	4.4%	1.1%
Stage 4	CPOE, CDSS (clinical protocols)	3.5%	0.8%
Stage 3	Clinical documentation (flow sheets), CDSS (error checking), PACS available outside Radiology	43.7%	17.1%
Stage 2	Clinical Data Repository, Controlled Medical Vocabulary, Clinical Decision Support, may have Document Imaging	31.3%	34.2%
Stage 1	Ancillaries – Lab, Rad, Pharmacy – All Installed	7.8%	12.6%
Stage 0	All Three Ancillaries Not Installed	7.9%	34.2%

Data from HIMSS Analytics™ Database

N = 3,867 / 1,303

EMR Adoption Model℠

		CA	PPS
Stage 7	Medical record fully electronic; HCO able to contribute CCD as byproduct of EMR; Data warehousing in use	0.0%	0.4%
Stage 6	Physician documentation (structured templates), full CDSS (variance & compliance), full R-PACS	0.0%	1.0%
Stage 5	Closed loop medication administration	1.0%	4.4%
Stage 4	CPOE, CDSS (clinical protocols)	1.0%	3.4%
Stage 3	Clinical documentation (flow sheets), CDSS (error checking), PACS available outside Radiology	18.7%	42.9%
Stage 2	Clinical Data Repository, Controlled Medical Vocabulary, Clinical Decision Support, may have Document Imaging	29.6%	32.8%
Stage 1	Ancillaries – Lab, Rad, Pharmacy – All Installed	13.0%	7.7%
Stage 0	All Three Ancillaries Not Installed	36.7%	7.4%

Data from HIMSS Analytics™ Database

N = 1,257 / 3,913

Medicare Incentives- Physicians

- Definition of Eligible Professional means a physician as defined in Section 1861 (r) of the Social Security Act:
  - Doctor of Medicine or Osteopathy
  - Doctor of Dental Surgery or of Dental Medicine
  - Doctor of Podiatric Medicine
  - Doctor of Optometry
  - Chiropractor
- Incentive value to be 75% of allowed Medicare charges for professional services for a payment year with yearly maximums

Medicare Incentives- Physicians

- 75% of allowed Medicare Charges for professional services a payment year
  - e.g. 2011 = $18K, 2012 = $12K, 2013 = $8K, 2014 = $4K, 2015 = $2k… for 5 years
  - Maximum incentive of $44K
  - only applicable for 2011-12, and is reduced starting 2013, all payments end in 2016
  - Incentive to adopt incurs a 1% reduction starting in 2015, and reduces 1% each year until 2018
  - In 2018 if its determined that less than 75% of eligible professionals are Meaningful Users, a reduction of no more than 5% can be assessed by the Secretary
  - If providing service in a HPSA, incentive can be bumped 10%

Medicare Incentives- Physicians

- Paid single, consolidated, annual incentive payment to EPs
- Hospital based providers are not eligible
- EPs select one tax identification number to receive any applicable EHR incentive payment.

Medicare Incentives- PPS Hospitals

- Those that are meaningful users by 2013 are eligible for full 4 years of incentive payments
- Penalties for non-users starting in 2015
- Early adopters rewarded, since $s are paid whether you implemented 5 years ago or any time prior to 2013

Medicare Incentives- CAHs

- CAHs that are meaningful users by 2011 are eligible for 4 years of enhanced Medicare payments (20% over Medicare Share with charity adjustment) with immediate full depreciation of certified EHR costs, including undepreciated costs from previous years.
- Penalties for non-users starting in 2015 (2015 .33% reduction in Medicare reimbursement increases to 1% reduction in 2017)
- Early adopters are not rewarded, since most of their investments have already been made and may be fully depreciated

Medicare Incentives- PPS Hospitals

Incentive payment per PPS Hospital for EHR Meaningful Use Adoption:

$2M Base + Discharge Payment x Medicare Share

Discharge Payment

- 1st – 1,149th discharge = $0/discharge
- 1,150th – 23,000th discharge = $200/discharge
- 23,001st discharge or more = $0/discharge

Medicare Share

Estimated # of inpatient-bed days with payment under Part A **+** Estimated # of inpatient-bed days for those enrolled with Medicare Advantage Part C

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Estimated total # inpatient days **x** Percentage of an eligible hospital's total charges that are not charity care

Medicare Incentives- CAHs

CAH enhanced Medicare payment formula ("formula"):

Total EHR Costs X (Medicare Share + 20%)

Medicare Share

(Estimated # of inpatient-bed days with payment under Part A **+** Estimated # of inpatient-bed days for those enrolled with Medicare Advantage Part C)

÷

(Estimated total # inpatient days **x** Percentage of an eligible hospital's total charges that are not charity care)

Medicare Incentives Applied- CAHs

I.	Est. Avg. Total "Eligible Certified EHR" Capital Cost per "Meaningful" CAH	$1,500,000
II.	Est. of Undepreciated Costs When CAH becomes "Meaningful" (80% of Line I)	$1,200,000
III.	Est. Avg. Medicare "Incentive" Share (Inpatient & Charity Stimulus Formula)	65%
IV.	Estimated Accelerated Depreciation II x III	$780,000
V.	Incentive Add-on	20%
VI.	Value of 20% Add-on (II x V)	$240,000
VII.	Est. Accelerated Depreciation + 20% Add-on (Total IV+V)	$1,020,000
VIII.	Est. Medicare Share Based on Traditional Allocation Cost Report	45%
IX.	Est. Traditional Medicare Cost Reimbursement Would Have Received (II x VIII)	$540,000
X.	**Est. Net Incentive Typical Eligible Hospital (VII-IX)**	**$480,000**

- This would be done through Interim Payments

Medicaid

- EHR Incentive Payments are available through the Medicaid program to:
- Physicians
- Nurse Practitioners
- Nurse Midwives
- Rural Health Clinics
- Federally Qualified Health Centers/ RHCs
- Hospitals

Medicaid Incentive Program Qualifications

- Provider must demonstrate meaningful use of the EHR technology through a means approved by the State and acceptable to the Secretary.
- In determining what is “meaningful use,” a State must ensure that populations with unique needs, such as children, are addressed.
- A State may also require providers to report clinical quality measures as part of the meaningful use demonstration.
- In addition, to the extent specified by the Secretary, the EHR technology must be compatible with State or Federal administrative management systems.

Medicaid Eligibility: "Practices Predominantly" & "Needy Individuals"

- **EP is also eligible when *practicing predominantly* in FQHC/RHC providing care to *needy individuals***
- **Proposes *practicing predominantly* is when FQHC/RHC is the clinical location for over 50% of total encounters over a period of 6 months in the most recent calendar year**
- ***Needy individuals* (specified in statute) include:**
  - Medicaid or CHIP enrollees;
  - Patients furnished uncompensated care by the provider; or
  - furnished services at either no cost or on a sliding scale.

Medicaid Eligibility: Hospital-based EPs, Statute

- **Statute specifies most EPs must not be *hospital-based* for participation**
  - Does not apply to EPs practicing predominantly in FQHC/RHC
- ***Hospital-based* is an EP who "furnishes *substantially all* of the individual's professional services in a hospital setting…"**
- **Determination must be made based on site of service, as defined by Secretary**

Eligibility: Hospital-based, NPRM

- **Propose to use place of service codes from claim forms**
- **If more than 90% of the EP's services are conducted in an inpatient hospital, outpatient hospital, or ER:**

  = *hospital-based* (i.e., ineligible)
- **States may make the determination**
  - this methodology will be included in the SMHP
- **Accepting comments (could change)**

EPs at Rural Health Clinics clarified

The avenue for participation for an EP is:

- Is an MD, NP, CNM, dentist or PA (insofar as the PA works at an RHC that is PA-led)
  - Meets patient volume requirements; or
  - "Practices predominately" at a RHC (= more than 50% of encounters are at an RHC over 6 mos); and if at least 30% of encounters were with "needy individuals"
- Non-hospital based requirement does not apply to EPs at RHCs/FQHCs
- Must meet other eligibility criteria (e.g., AIU or MU, certified EHR, non-sanctioned, licensed)

Medicaid Incentives- Providers

- Eligible Professionals are eligible for either Medicare or Medicaid Incentives – NOT BOTH
- Eligible Professional cannot be Hospital based and must have a patient load of 30% Medicaid
  - Payments cover up to 85% of net allowable costs to adopt and operate EHR Technology
  - Allowable costs for the first year are to be the average costs expended for the implementation or upgrade of an EHR system to not exceed $25 K and cannot occur after 2016
  - Subsequent years are to be calculated at 85% 0f 10K to not exceed 2016

Defining “Average Allowable Costs”

- The term `average allowable costs‘ means the average costs for the purchase and initial implementation or upgrade of such technology (and support services including training that is necessary for the adoption and initial operation of such technology.

Medicaid Incentives- Providers cont'd

- If provider is a Pediatrician, then patient volume must be 20% Medicaid and the incentives will be taken at 2/3 the rate
- If eligible provider practices at a FQHC or RHC then patient volume must be 30% "needy" Individuals
  - Medicaid, sliding fee, uncompensated care, or receiving assistance under Title XIX

Medicaid Incentives- Hospitals

Example:

- If EHR Cost = $5,000,000 and Medicaid Share = 15%

	Overall Hospital EHR Amount
Year 1 Transition Factor = 1	1 x $5,000,000 = $5,000,000
Year 2 Transition Factor = ¾	¾ x $5,000,000 = $3,750,000
Year 3 Transition Factor = ½	½ x $5,000,000 = $2,500,000
Year 4 Transition Factor = ¼	¼ x $5,000,000 = $1,250,000
Total 4 Year Sum $	**12,500,000**

Aggregated payment maximum = Total 4 Year Sum x Medicaid Share **= $1,875,000**

50% of aggregated payment maximum could be received in one year
Or
90% could be received in a two-year period

- 10% administrative fee for State match, including tracking of meaningful use, conducting oversight, and pursuing initiatives to encourage adoption

Medicaid Incentives-Hospitals

- Payments are made over 3-6 years depending on the state
- No payment may exceed 50 percent of overall 4 year amount in any year; no consecutive payments shall exceed 90 percent of overall amount
- No payments to be made beyond 2016 unless hospital received payment in the previous year

Activities Required for Incentives: Overview

- Adopt, implement, upgrade (AIU)
  - First participation year only
- Meaningful use (MU)
  - Successive participation years; and
  - Proposed option for early adopters in year 1
- **States may propose to CMS for approval limited additional criteria for MU, beyond the NPRM**
  - NPRM is the MU base-level requirement
- **Prioritizing coordination between:**
  - CHIPRA and HITECH

Activities Required for Incentives: Adopt, Implement, or Upgrade

Adopt: Acquired and installed

- **e.g., evidence of acquisition, installation etc.**

Implement: Commenced utilization

- **e.g., staff training, data entry of patient demographic information into EHR, data use agreements**

Upgrade: Version 2.0; expanded functionality

- **e.g., ONC EHR certification (short-term) or additional functionality such as clinical support or HIE capacity (longer-term)**

Activities Required for Incentives: Meaningful Use

A provider must demonstrate meaningful use by:

1. **Use of certified EHR technology in a meaningful manner such as through** e-prescribing;
2. **That the certified EHR technology is connected in a manner that provides for the** electronic exchange of health information **to improve the quality of care; and**
3. **In using this technology, the provider submits** clinical quality measures **in a form and manner approved by the Secretary**

Activities Required for Incentives: Meaningful Use, Stage 1

- For Eligible Professionals:
  - Three (3) core measures for all EPs
    - Tobacco screening
    - Blood pressure management
    - Medication management in the elderly
  - And selection of a set of specialty measures (e.g. primary care, pediatrics, etc) and report on all of them, as applicable.

- For Hospitals:
  - Must attest to (and later report on) all proposed QMs for each patient to whom the QM applies, regardless of payer, discharged from the hospital during the reporting period
  - Medicaid's alternative list: includes newborn measures, pediatric measures and "never event" measures

Activities Required for Incentives: Hospitals

- Eligible hospitals, unlike EPs, may receive incentives from Medicare and Medicaid
  - Subsection(d) hospitals, also acute care, but not CAHs
- Hospitals meeting Medicare MU requirements may be deemed for Medicaid , even if the State has an expanded (approved) definition of meaningful use

Activities Required for Incentives: Other Priorities

- **There is a deliberate overlap between the CHIPRA core measures and the Stage 1 measures for MU.**
  - BMI 2-18 yrs old
  - Annual hemoglobin A1C testing (all children and adolescents diagnosed with diabetes)
  - Pharyngitis - appropriate testing 2-18 yrs old
  - Follow-up care for children prescribed attention-deficit/hyperactivity disorder (ADHD) medication

Activities Required for Incentives: Timing Overview

- **The Medicaid EHR Incentive Program starts in 2011 and ends in 2021**
- **The latest that a Medicaid provider can initiate the program is 2016**
- **A Medicaid provider can initiate the program under the Adopt, Implement and Upgrade bar but in their 2nd and subsequent years, they must meet MU at the stage that is in place, per rule-making (Stage 3 by 2015).**

Conditions for State Participation

- **Prior approval for reasonable administrative expenses (P-APD, I-APD)**
- **Establish a State Medicaid HIT Plan (SMHP)**
- **State may receive 90% FFP and 100% FFP for the payments themselves**
- **NPRM defines numerous previously undefined terms in CFR**
  - Medicaid Management Information Systems (MMIS)
  - Medicaid IT Architecture (MITA)

90/10 Administrative Funding to States

Statutory Conditions of Use of the HITECH Admin Funds:

1. **Administration of incentives, including tracking of meaningful use by Medicaid EPs and eligible hospitals;**
2. **Oversight, including routine tracking of meaningful use attestations and reporting mechanisms; and**
3. **Pursuing initiatives to encourage the adoption of certified EHR technology for the promotion of health care quality and the exchange of health care information.**

State Medicaid HIT Plans

- **3 Key Elements: What is the current HIT landscape? What is the State's Vision for the next 5 years?** How will they implement and oversee a successful EHR Incentive Program?
- **NPRM proposes States uses MITA principles in developing SMHP**
- **SMHP will include State's methodologies for verifying eligibility; disbursing payments; coordinating with stakeholders; contracting; privacy & security; curtailing fraud & abuse; and other activities**

Financial Oversight & Program Integrity

- **States and CMS must assure there is no duplication of payments to providers (between States and between States and Medicare)**
- **States are required to seek recoupment of erroneous payments and have an appeals process**
- **CMS/Medicaid has oversight/auditing role including how States implement the EHR Incentive Program (90% FFP) and how they make correct payments to the right providers for the right criteria (100% FFP).**

And for Alabama?

- On February 26, 2010 Alabama was awarded federal matching funds for EHR Incentives Program
- Matching funds for state planning activities necessary to implement the electronic health record (EHR) incentive program established by the American Recovery and Reinvestment Act of 2009 (Recovery Act).
- Awarded $269000

Notable Differences Between Medicare & Medicaid Incentive Programs

Medicaid	Medicare
Voluntary for States to implement	**Feds will implement**
No Medicaid fee schedule reductions	**Medicare fee schedule reductions begin in 2015 for physicians who are not MUers**
AIU option is for Medicaid only	**Medicare must begin with MU in Y1**
Max EP incentive is $63,750	**Max EP incentive is $44,000**
States can make adjustments to MU (common base definition)	**MU will be common for Medicare**
Medicaid managed care providers must meet regular eligibility requirements	**Medicare Advantage physicians have special eligibility accommodations**
Program sunsets in 2021; last year a provider may initiate program is 2016	**Program sunsets in 2016; fee schedule and market basket update reductions begin in 2015**
Five EPs, two types of hospitals	**Only physicians, subsection(d) and critical access hospitals**

What's Coming?

- This is not the end, this is only stage 1
- Stage 2 and 3 will come out in 2013 and 2015
- Stage 2 would expand upon the Stage 1 criteria in the areas of disease management, clinical decision support, medication management, support for patient access to their health information, transitions in care, quality measurement and research, and bi-directional communication with public health agencies.
- Stage 3 would focus on achieving improvements in quality, safety and efficiency, focusing on decision support for national high priority conditions, patient access to self management tools, access to comprehensive patient data, and improving population health outcomes.

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