

Members of the Adoption/Certification Workgroup:

On July 14th the Office of the National Coordinator for Health Information Technology (ONC) has helped organize a call for the Adoption/Certification Workgroup. There are two main objectives to this call, they include:

1. **Understand the numerous efforts ONC is making in the areas of Certification and Adoption.** We will be given an update as to the data being requested/collected by ONC and the numerous projects which ONC has initiated in these areas. This will serve as an excellent background for a discussion on how we can best assist ONC.
2. **Prioritize the areas we would like to focus on and the best approach to understanding the issues and providing recommendations to ONC.** Below are the original questions/comments which we sent to the group for discussion. Attached to this memo we have included the comments/discussion for each of the suggested areas. The list below (and associated comments) will serve as a baseline with which we can have this discussion. However, if there are other areas which we deem more appropriate, we can surface them in this discussion.

Areas of focus:

1. Recommendations on getting the EMR naysayers to the table. There are arguments for not installing an EHR, but are these folks looking at the whole story and seeing the broader picture? This could be done through; survey and/or holding a public hearing (maybe in September?), or other ideas?
2. Coordinate with the Implementation workgroup (Standards Committee) on issues related to interoperability (Lab connectivity specifically is a big deal for us). This could be accomplished by having members of the Adoption/Certification Workgroup being integrated into the Implementation Workgroup.
3. Examine adoption challenges faced by some specific market segments (e.g. small physician groups, rural hospitals, safety net institutions). This could be done through a Public Hearing.
4. Monitor the certification process to determine the effectiveness/problems with the new approach.

Some other ideas which we discussed are listed below. ONC has stated that these may overlap or be redundant with the contract/grant work ONC currently has underway. However, if we felt strongly we could/should put effort into these issue, then we can build them into our plans and determine the best approach to addressing them.

5. REC best practices. It is early in the REC process, but it would not hurt to learn more about the plans of the REC and create processes for sharing/enhancing their capabilities.
6. Adoption is really the “use” part of Meaningful Use. Look at best practice use of EHR and ways these best practices could be shared.
7. Training and education.

8. Defining the hurdles for adoption and approaches to get over them.
9. Getting the real picture of adoption. Get some type of baseline statistics to measure against.
10. Success stories.
11. Patient Access to Data issues.

Thank you all for the time and effort you apply to these important matters. As we can see from the Certification efforts, ONC has listened to our recommendations and as a workgroup we have had a major impact on the rules and approach.

We look forward to an informative and productive call on the 14th.

Sincerely,

Paul Egerman
Marc Probst

ATTACHMENT – Detail from email exchanges

Areas of focus:

1. Recommendations on getting the EMR naysayers to the table. There are arguments for not installing an EHR, but are these folks looking at the whole story and seeing the broader picture? This could be done through; survey and/or holding a public hearing (maybe in September?), or other ideas?
 - JOE HEYMAN - Rather than just concentrating on naysayers, why not look at those who represent those most typically finding difficulty in adoption (physician organizations such as AMA, AAFP, etc.?)
 - LARRY WOLF - I read this question as: what is being said against EMR adoption and what can be done about changing minds or at least, changing the dialog and increasing adoption. There are a few things going on here. (a) There are “naysayers” who are publicly speaking out against EMR adoption. Seems we could do a blog/literature review and see what they’re saying. Some of what they’re saying might help us shape the arguments about the value of EHR adoption. (b) However, I think this group is different from those who just don’t plan to adopt. I recently asked one group of physicians what they were planning to do about the EHR incentives and about half of them said: “retire” or otherwise ignore that this was happening. These folks are not likely to come to a hearing but we might get to them through their professional associations. (c) Then there are those who are still on the fence, not sure what to do or why to do it other than carrots and sticks from Washington. For them, especially, we need to clarify the why’s and how’s of EMR adoption. All of this has me thinking about a book I just finished (“Switch: How to change things when change is hard” by Chip and Dan Heath <http://heathbrothers.com/switch/>). They suggest a three part approach to address the logical aspects (why EMR’s are good for you, your patients, the community, ...), the emotional aspects (how using an EMR is/isn’t part of your identity as a physician, how using one might align with fundamental values, ...) and the doing part (EMR adoption is seen as risky and expensive, what are the ways in which the risks and costs can be reduced?) ... In our early hearings, we heard from some of the successful early adopters. Perhaps we can find some more recent adopters and learn from them... possibly in our day jobs and/or for ONC staff to do this (since there is value in going where they are, where the care is being delivered, not in a DC conference room).
 - JOAN ASH - We could think of these people as skeptics, and in our role as the adoption work group, it would seem to be within our purview to understand their skepticism. Maybe we could think of it as trying to understand the barriers and the skeptics have usually given a lot of thought to barriers. If we want a national view of the number and type of skeptics and perhaps key reasons, a structured survey would be best. Another possibility is a telephone survey during which there could be some give and take—my personal favorite. Unfortunately, any survey, no matter how administered, beyond nine people, would need to be approved by the OMB and I understand they need to see the final “instrument” at

least 18 months in advance. So even though a survey would be great, it's probably not practical.

2. Coordinate with the Implementation workgroup (Standards Committee) on issues related to interoperability (Lab connectivity specifically is a big deal for us). This could be accomplished by having members of the Adoption/Certification Workgroup being integrated into the Implementation Workgroup.
 - JOE HEYMAN - Seems reasonable but I do believe there is a difference between adoption and implementation.
 - LARRY WOLF - Yes, shared efforts would be good to coordinate policy with standards.
 - JOAN ASH - Sounds like a good idea. I don't know that we should go much further with it though, since it's not a main focus for us.
3. Examine adoption challenges faced by some specific market segments (e.g. small physician groups, rural hospitals, safety net institutions). This could be done through a Public Hearing.
 - JOE HEYMAN - Same as #1.
 - LARRY WOLF - Might look to the REC's to be the eyes and ears for this, especially since these are their target audiences. Bring them in for a Public Hearing.
 - JOAN ASH - This falls into the "barriers" bucket like #1 and, though some kind of survey would get better data, a hearing is our only option.
4. Monitor the certification process to determine the effectiveness/problems with the new approach.
 - JOE HEYMAN - Also should monitor the rate of adoption and try to understand why it is what it is as the law goes into effect.
 - LARRY WOLF - Yes, get data from the Certification process and Meaningful Use payments to track what's happening. Something for either public hearing (from the certification bodies and from CMS) or reports by the ONC staff.
 - JOAN ASH - This is absolutely within our purview and I think it should be our focus more than anything else. I think we need to carefully plan how to do this. For now, we should track the temporary certification process against how well it's meeting goals to help provide objective feedback before the permanent program starts.

Some other ideas which we discussed are listed below. ONC has stated that these may overlap or be redundant with the contract/grant work ONC currently has underway. However, if we felt strongly we could/should put effort into these issue, then we can build them into our plans and determine the best approach to addressing them.

5. REC best practices. It is early in the REC process, but it would not hurt to learn more about the plans of the REC and create processes for sharing/enhancing their capabilities.
 - LARRY WOLF - Isn't this what the national Health Information Technology Research Center (HITRC) is supposed to do (coordinate, share best practices, etc.). Perhaps a hearing where we hear from them.

- JOAN ASH - This is somewhat outside our charter, but from the point of view of adoption, we should at least learn what they believe the barriers are.
6. Adoption is really the “use” part of Meaningful Use. Look at best practice use of EHR and ways these best practices could be shared.
 - JOE HEYMAN - I think adoption goes beyond the “use” in “meaningful use” in that it is related to whether the cost in dollars, resources, time, and frustration are worth the proposed benefits of efficiency, quality, safety and personalized care.
 - LARRY WOLF - Yes. What are the underlying drivers/barriers to adoption, especially since Meaningful Use is being described as a minimum set of activities?
 - JOAN ASH - Important as this is, I think it’s a bit beyond our charge. I believe other groups are working to develop best practices and useful tools. In fact, just about every ONC funded group seems to be doing something along these lines.
 7. Training and education.
 - JOE HEYMAN - RECs only there for 100,000 PCPs, but what about the other 500,000 or so physicians?
 - LARRY WOLF - There is more going on than REC’s that related to training (Community colleges, curriculum development, university training, competency exams, ...). How are these efforts working? ... And more generally, what are the work force issues and how are provider organizations meeting them?
 - JOAN ASH - Again, this seems outside our charge and evaluation of these efforts is built into other programs.
 8. Defining the hurdles for adoption and approaches to get over them.
 - JOE HEYMAN - See #6 and #4 above.
 - JOAN ASH - This should be one of our key foci—identification of the barriers and strategies for overcoming them.
 9. Getting the real picture of adoption. Get some type of baseline statistics to measure against.
 - JOE HEYMAN - See #4 above.
 - JOAN ASH - We should find out what else is being done about this. It seems like someone else should be gathering the data, but we should have access to it and regularly review it to we can track progress over time and investigate barriers when they appear.
 10. Success stories.
 - Good.
 - JOAN ASH - We should be given access to these, but gathering them seems outside of our scope.
 11. Patient Access to Data issues.
 - JOE HEYMAN - Physician access to meaningful aggregated and individual data equally, if not more, important.
 - LARRY WOLF - Both are important. The Patient Engagement hearing was full of good insights. A follow-up would be informative as well. And other users of data, including what makes for effective care coordination (the data, the process flows, the people/roles, ...) as well as use of data to improve organization quality and effectiveness (that dang ROI thing). There are good examples out there of EHR data being helpful to providers in actually managing a population of patients

(engagement, outreach, just knowing the actual outcomes for the providers' practice...). Let's help find and publicized them.

- JOAN ASH - I don't quite see how this fits into adoption and certification except tangentially. I think we should focus on other areas.

From George Hripcsak:

We could frame it in terms of what levers we have to fix whatever we uncover:

- Meaningful use. How aggressive should we be in Stage 2?
- Implementation workgroups. Should we aim for the optimal solution or the most feasible solution?
- ONC recommendations. What can we do with RECs, training, etc?

As for whom to survey:

- Successes - we want to learn from them.
- Failures - perhaps the most important group. Presumably, they have no ulterior motives for failure, and we can learn the most.
- Non-adopters - those who decided not to try. We need to distinguish wise judgment on their part from poor marketing on ours.
- Naysayers - here I am including everyone who is not an eligible professional or a hospital who is saying no. They generally have other interests, but important to listen to them, too.

George Hripcsak #2 - I like Paul's primary focus on certification. I do wonder, though, whose job it is to define what we mean by adoption or participation and what we need to measure. We intend to adjust MU and certification based on adoption, but I think most of those intentions have been fairly vague. Based on attempted adoption, successful adoption, big or small practices, # patient affected, proportion of criteria met, or what? At the very least, MU and A/C need to compare notes going forward.

From Larry Wolf:

One general area that seems under represented is HIE (noun and verb). Each of the states has one or more planning efforts underway. Some of these are now live or will be soon. While the Policy Committee has workgroups addressing various aspects of this, perhaps we can look at how HIE supports the care process and might even help drive adoption of EHR's. Certainly lack of interoperability has been one of the problems with past implementation of EHR's.

Larry Wolf #2 - A question for the group: Should we address the workforce part of our charter?

When we first started, our charter included workforce. I'm hearing that the demand for HIT staff with implementation experience is heating up. Providers with implementation projects to prepare for Meaningful Use are not finding the people they need and recruiters are getting creative with referral bonuses to increase their options for candidates. This is likely to get worse as the months

go by and more providers, software vendors and consulting groups are all vying for the same labor pool.

ONC, under HITECH, is funding several education initiatives (at community colleges and universities) in addition to the Regional Extension Centers. These initiatives are designed to improve people's HIT skills and supply the needed workforce.

We have not had much discussion of any of this as a workgroup or with the full committee. Is this our topic to raise?

From Charles Kennedy:

My thoughts on where we could help ONC focus on several areas where I think our current programs will struggle. One area is the physician's personal sense of benefit from EMRs which many find too low to get them motivated to go down a path disruptive to their practice and thus drive comments like Larry referred to in his note. Further, the potentially negative impact to MD productivity (thus revenue) makes our challenge all the bigger; ARRA financial incentives or not. Therefore, I would suggest we look at how we can increase the value of these tools to physicians who are currently in practice. These areas could be:

- Reducing the administrative burden from interacting with health plans--- Many health plans have prior authorization procedures. Could we identify and investigate a process where a health plan would certify a set of algorithms which would interact with an EMR and make authorizations almost invisible to the doctor? Technically, what I am wondering about is an intersection between a 278 transaction and a CCD document and seeing if the clinical data in the CCD could be used for fully automated UM. From an HIT Policy Committee, I think our activity might be framing up at a policy level how the adoption of Health IT can reduce administrative burdens for common functions like referrals and auths and then collaborating with AHIP around a process to develop this on the health plan side. If we can make the headache of authorizations go away, I think that might get a meaningful number of physicians to see value in EMR adoption.
- Providing additional financial upside to physicians—Currently, ACOs are thought to be a structural innovation that may more appropriately align incentives and provide physicians with financial upside from efficient and effective care delivery. Although HIT should help with the ACO opportunity, the intersection of HIT and how it can enable/enhance ACOs is not an area with a lot of understanding to it. Health Affairs had an article in the April edition which chronicled one group's implementation experience with a well known EMR that was hoped to improve medical home performance. Should we take on this area and develop recommendations to be considered by future certifications that would help ensure certified products can help with ACO management and execution?
- Secondary uses of data—Agree this is an important area however we might assess how to make use of this data in ways that more directly benefit physicians such as participation in database driven trials (Phase 4), comparative effectiveness, and other research driven endeavors. From a policy perspective, it would be good to

understand how existing EMRs can support these needs (and financial opportunities for docs) and what types of enhancements (technical, data...) might be needed.

From Stephen Downs:

My observation is that this group has been most effective when we've been given a clear task – a problem that ONC needs solving – and we had to focus on recommending a solution, as was the case with the certification process. So I'd argue that we try to stick to one or two key issues where we can add the most value.

Given that we developed the recommendations for certification, I believe we have a responsibility to monitor how that plays out and, if there are issues, make recommendations for improvements. On the adoption front, I'd be interested in having us play a role where we review the adoption data as they become available, probe where it makes sense (e.g. surprising findings) through hearings, etc. and then make recommendations for strategy adjustments as needed. We might need to get a handle on what adoption data will be available as a prerequisite step.

From Paul Tang:

I very much agree with Steve. All of the WGs function best when focused on a limited, yet critical, charge. The central focus for this group is certification and adoption. Both are huge topics with significant implications for the whole incentive program. Since the certification strategy and criteria were part of this group's recommendations, it would make the most sense if this group were able to monitor how the certification process is going, and whether it is achieving the desired outcomes (of certification). Also examining the implications of the certification program on adoption would be an essential element of the evaluation.

The Meaningful Use WG also plans to include feedback from the actual participation in the MU incentive program to look at the impact of the MU criteria on successful adoption and qualification for the HIT incentives. So, the combined WG efforts would provide two important perspectives on the overall success of the HIT incentive program.

Paul Tang #2: Ah, yes. Good memory, Larry. We did bundle the workforce issue into "adoption" when we labelled the WG as certification and adoption. That's another important aspect of achieving the objectives of the HIT incentive program (using HIT to improve outcomes). We need good software and infrastructure, good implementation (workforce), and good use (MU).

Paul Tang #3: You're absolutely right, Joe, there is no shortage of challenges to getting meaningful value out of these systems. And unfortunately, they are all in series, so that if you make a major mistake in any one of these steps, the value can be hard to realize. So, we have to work on all these things in parallel, from a public policy point of view. We do need to measure (and improve) the success rate of adoption (including meaningful use), but we also need to assess the effectiveness of our levers with vendors through certification. You've probably seen both good products poorly implemented and attempts at good implementation using poor products. We need to raise the bar for "certified" products as one of those pinch points that smaller

practices are least able to evaluate thoroughly. In true HITECH fashion, we need to address all the challenges – yesterday.

From Joseph Heyman (#2):

While I agree that it is important to monitor how the certification process is going, from my vantage point ADOPTION is much more important. If people are not adopting the technology, it doesn't matter how certification is going. And as a solo physician in private practice who has himself adopted this technology, and has helped his community adopt this technology, I can tell you that adoption has many more real world problems than does certification for the practicing physician. The physician still has to choose vendors, hardware, hosted vs. non-hosted, training, and investing.

Certification helps that physician know what NOT to choose, but not what she needs! Since the final leg in obtaining true quality improvement from this technology, adoption is the rate limiting factor! I feel we should focus on the progress to adoption and where improvement is needed.

From Scott White:

I agree that our best efforts should be put toward the "Adoption" part of our charter. We could focus early on with addressing barriers that have providers indicating why they are not going to adopt, thereby increasing the possibilities for greater traction. Once funding/certification applications begin we should work on getting some hard data on where providers are trying and where they are not. From there we should be able to focus our efforts and assist in their problems. Once we have a significant group adopting the technology we could possibly move to areas where they are having difficulty in achieving "meaningful use".

This seems to be an area that the RECs will be focused on but I am unclear as to where they are in the process and how we will gauge their success or failure. My personal physicians and those of my family seem to be unclear on many aspects of this including funding, requirements and meaningful use. I suspect many small physician offices are experiencing the same problem. The hospitals seem to be further ahead in the discussion and consideration but are struggling with how to make it all work. This would indicate to me that the RECs haven't penetrated very far if at all.

From Rick Chapman:

I agree with Joe. We should certainly continue to monitor the certification process but adoption is where we should focus. Adoption is where the rubber meets the road and it is hard work that requires skilled resources and effective management. In my career as CIO of some of the nations largest investor owned hospital chains (eg HCA).. I have had experience with literally hundreds of EMR implementation projects across the country. Our experience indicated that a critical path oriented methodology with peer level education/training staff (nurses,physicians, pharmacists, medical technologists, Radiology techs etc) and utilizing best practices (learned from previous projects) yielded the best and most timely results. This obviously has to be complimented with management oversight and milestone reviews. The point to all of this is we

should monitor the adoption process and seek input from the Extension Centers...vendors... and providers as well as our Beacon Communities to ensure and support successful adoption. A similar but separate process should be undertaken to monitor Meaningful Use. I also think there is linkage to workforce development in that supply of I/T and Peer Clinical training personnel may quickly become critical.