



**Testimony before the
HIT Policy Committee
Meaningful Use Workgroup Hearing
May 13, 2011.**

Prepared by Bethany M. Gilboard, Director, Massachusetts e Health Institute Regional Extension Center.

Good afternoon Chair Dr. Tang and Co-Chair Dr. Hripcsac and members of the Meaningful Use Workgroup. My name is Bethany Gilboard, I am Director of the Massachusetts e Health Institute Regional Extension Center and I appreciate the opportunity to provide testimony on this important topic.

Background: The Massachusetts e-Health Institute (MeHI), a non-divisible component of the Massachusetts Technology Collaborative (MTC), is the state's designated entity for health care innovation, technology and competitiveness. Established by an act of the Massachusetts Legislature, MeHI is responsible for advancing the dissemination of health information technology across the Commonwealth, including the deployment of electronic health records systems (EHRs) in all health care provider settings that are networked through a statewide Health Information Exchange. Massachusetts Governor Deval Patrick designated MeHI as the state's Regional Extension Center and Health Information Exchange. We are an organization that offers a variety of programs and services designed to help clinical providers transition into a practice that meaningfully uses electronic health records. We are also the designated Health Information Exchange for the Commonwealth (Statewide HIE) and work closely with the state's Office of Medicaid.

The Regional Extension Center, through an extensive screening process, has developed a comprehensive list of certified Implementation and Optimization Organizations (IOOs) who provide the "boots on the ground" technical support, training and implementation programs to assist Primary Care providers to successfully implement and optimize an electronic health record so that they can attest successfully and receive the CMS incentives. Massachusetts is the first state in the nation to reach its federal goal in the enrollment of health care providers to adopt the use of electronic health records. Through the Massachusetts Regional Extension Center, 2,500 health care providers have enrolled with the Massachusetts eHealth Institute (MeHI) as part of the state's efforts to accelerate the adoption of electronic health records in the Commonwealth.



The questions posed, by the Meaningful Use workgroup, were submitted to our IOOs. This testimony reflects their opinions and experiences working with a subset of our 2500 Priority Primary Care providers enrolled in the Regional Extension Center. The commentary is based upon actual engagements with a cross section of providers.

The breakdown of our REC membership is as follows:

- Community Health Centers 29%
- Private practice 45%
- Practice Consortiums 16%
- Public hospitals 10%

Approximately two thirds of our enrolled members have an electronic health record, but are awaiting their upgrade to a federally certified version and the remaining third are beginning the process of evaluating EHR vendors with the assistance of the IOOs. Of our 2500 enrolled providers we anticipate approximately 65% will apply for reimbursement for Meaningful Use of HIT via Medicare and 35% via Medicaid.

Panel 4: Experience from the Field:

Do your REC enrolled members plan to apply for reimbursement for Meaningful Use of HIT via Medicare and Medicaid?

All 2500 enrolled providers include both Medicare and Medicaid. We have not analyzed each provider's panel but a significant number will qualify for the Medicare reimbursement program. We have enrolled forty -six Community Health Centers (CHC). Approximately two thirds of the CHC's either have an EHR and are awaiting their upgrades and the remaining centers are currently evaluating EHR systems. All of the CHCs will attest to Adopt, Implement or Upgrade in early Fall when the Massachusetts Medicaid program is operational. Additionally, we have over 460 pediatric providers, of whom a majority will apply for the Medicaid incentive payment.

When do you plan to begin your Meaningful Use reporting period?

Although two thirds of our providers are currently live on an EHR, less than 60% have taken their upgrades for a federally certified version. Many are awaiting upgrades. However, in anticipation of getting their upgrades, the practices are doing what they need to do with regard to workflow enhancements, hardware

upgrades and education regarding the MU measures. We anticipate that over 100 providers' plans to attest as early as late May for Medicare. We have several hundred providers who have indicated that they plan to attest between June and October provided their upgrades are successful. It is anticipated that our state Medicaid plan will be approved in late spring and the program will be operational in either late August or early September. A large percentage of our Medicaid eligible providers will attest through Adoption, Implementation or Upgrade in early Fall. We anticipate that the majority of our Medicare providers will be ready by early 2012 to attest to Stage 1 Meaningful Use. Our Medicaid providers who do not currently have an EHR may take their time and wait for the Medicaid program to open.

Which objective requirements do you find easy to meet (or exceed)?

The following comments and table are based upon specific feedback from IOOs. For a consortium with hundreds of small provider offices, the core objective requirements that will be easier to meet include computerized provider order entry, drug-drug and drug-allergy checks, generating and transmitting permissible prescriptions electronically, recording demographics, maintaining an up to date problem list with active diagnoses, maintaining an active medication list, maintaining an active medication allergy list, recording vitals (height, weight, BMI, BP), recording smoking status, implementing one clinical decision support rule, protecting health information, and providing clinical summaries for patients at each office visit.

Experience from another IOO working with very small independent practices reports that a number of the core measures (e.g., 1-7) are fundamentals of any working EHR, and do not generally require anything more than very basic use.

The grid below reflects experience from the field working with REC enrolled providers.

Objective	Feedback
Use CPOE	
Enable drug-drug, drug-allergy interaction checks	Enable the functionality
Record problem list	Workflow for providers not used to using ICD codes vs. the written problem
Use eRX	Some provider simply prefer to print
Record active medication list	
Record active medication allergy list	

Which core objectives have posed the greatest challenges to you meeting the requirements (and why)?

The response to this question varies depending upon the size and structure of the organization working with physicians. For large integrated delivery systems also serving as IOOs, having more than one vendor in place for the ambulatory practices is challenging. These vendors will vary due to the different specialties supported. The multiple vendors pose a challenge to reach Meaningful Use requirements in a timely fashion. Providing patients with an electronic copy of their health information will be a challenge since the interpretation of the objective varies between vendors. Exchange of key clinical information among providers of care will pose a challenge due to the number of different vendors that the organization currently supports.

The grid below depicts some feedback from IOOs working with small independent physicians and the experience that they have encountered to date.

Objective	Feedback
Record demographics	Race and ethnicity questions are sometimes uncomfortable for practices
Record vitals	Some specialties just don't do it at every visit
Record smoking status	Needs to be set up as structured data with the standard categories which may not always be used traditionally
Report quality measures	Requires application functionality that many practices do not yet have because they do not have a certified version
Implement CDS	Depends on the application
Provide health information to patients	Easy enough if documentation is complete at the point of care
Provide clinical summaries to patients	Depends on documentation being complete at the point of care. This has been well received in some settings, but difficult in others. Specific issues include: (1) notes are not complete at the time of patient checkout, requiring the summary to be printed and mailed on the following day; (2) the requirement generates a large volume of unwanted paper (patients are uninterested), which is antithetical to the idea of a "paperless" office; (3) the summary format is lacking in narrative substance, and providers do not feel that it effectively empowers patient participation. There is still confusion about what is included, in the measure as defined but there is a loophole since you only have to

Objective	Feedback
	include what is in your EHR system. Is patient portal posting sufficient?
Exchange key clinical information	Requires dependence on the vendor's abilities or an exchange platform that is out side the control of the practice
Protect health information	

Which menu objectives have posed the greatest challenges to you meeting the requirement (and why)?

The table below addresses the menu items and challenges posed.

Menu	Feedback
Implement drug formulary checks	Depends on the availability of formulary information with the given vendor. Poses a challenge since not all insurance companies have signed up to be part of RxHub. This will be especially difficult for rural areas or self-funded plans and independent physicians.
Incorporate structure lab results	Need an interface or someone to enter data. It can be a no-brainer in many environments, however for clinics that do not have the option of an electronic lab interface (e.g., not offered by the local hospital), the manual data entry can be problematic for a number of reasons: (1) values must be input by a qualified clinical staff member (e.g., nurse), who's time may be in short supply in a small office; (2) if entered by a staff member who is not familiar with a particular lab, data may be entered incorrectly; (3) reaching the 40% goal may involve clinically unnecessary data input for certain specialties
Generate patients lists by condition	Depends on the registry functions, use of proper structured data and user ability to run reports
Send patient reminders	Need to identify the patient and then figure out how to contact them. If not automated, need to print out labels and create a process to send reminders.
Provide patient education resources	No feedback provided
Provide summary of care record for care transitions	No feedback provided
Capability for immunization registry reporting	Is dependent on factors outside the control of a practice measures (immunization and syndromic

Menu	Feedback
	surveillance) poses a challenge since the software has the technology to support this function but will the state be capable of accepting the transmission and if not, will an organization be penalized or have to purchase Is dependent on factors outside the control of additional modules in order to transmit the information.
Capability for syndromic surveillance reporting	Is dependent on factors outside the control of a practice measures (immunization and syndromic surveillance) poses a challenge since the software has the technology to support this function but will the state be capable Capability for syndromic surveillance reporting of accepting the transmission Capability for syndromic surveillance reporting and if not, will an organization be penalized or have to purchase additional modules in order to transmit the information.

How well have the Meaningful Use clinical quality measures aligned with other measures in common use in your field? How easy or difficult has it been to report them for this program?

In Massachusetts, the Meaningful Use clinical quality measures currently align with the Blue Cross Blue Shield of Massachusetts Accountable Quality Care Contract (AQCC) and the Medicare PQRI programs. This is relevant for physicians who are currently members of Independent Practice Associations, Physician Hospital Organizations or Integrated Delivery systems many of whom currently have an AQCC contract. Measures with similarities include the management of Hypertension, Diabetes, Chronic Obstructive Pulmonary Disease (COPD) and childhood obesity. Additionally, over 600 of our REC primary care providers are currently participating in the state's Patient Centered Medical Home Initiative and all of the clinical MU measures are incorporated into that program. The ease of reporting has yet to be determined as groups continue to align them with the Meaningful Use reporting and improve upon the current functionalities available in the electronic health record.

The challenge for meeting the MU Clinical Quality measures may be more significant for certain sub specialities and for small practices located in our western most counties of the state. This is primarily as a result of the limited organized managed care activity in that region The small practices have

historically done very little to implement quality metrics, due to the complexity and lack of organizational structure.

What have been the major challenges, especially external factors?

- Questions about interoperability, exchange of information with local hospital or other EHR's in the community. Vendor issues, etc public health/ surveillance option or other options are cost prohibitive (i.e. interface costs). There also continues to be confusion over the electronic test requirement.
- Timing about the Medicaid program and feeling a lack of urgency to move forward
- Lots of movement within the healthcare community with hospital acquisitions, physicians aligning with larger systems to see which will provide the most advantageous opportunity for EHR adoption, physicians looking to sunset their practice and evaluating employment opportunities by their local hospital so that they will not need to make a large investment in the technology.
- Access to Broadband in the more remote parts of the state
- Timeliness of vendor upgrades for certified versions, productivity loss, financial, costs, time, and resources.
- For physicians used to using an EHR with basic functionality, they understand the measures and are capturing a lot of the objectives and know what it is like to conduct an allergy check, but for those still on paper, many still have no idea about MU, no plans about what to do despite being enrolled with the REC.
- Concerns about computer literacy and the ability for physicians to input data into the EHR continue to pose challenges to adoption.
- Many EHR vendors will not visit smaller practice sites, the best they will do is a web demo in some cases. Very difficult to make a decision on a web demo
- Providers worry about having to click through many boxes and screens during patient visits potentially taking time away from the patient.

What do you estimate is your project cost to implement meaningful use?

This varies by practice type and we have not yet collected this data

If you have any additional questions you may contact me at 617 371 3999 ext 201 or email Gilboard@masstech.org Thank you again for this opportunity to present today.