



## PROPOSED TESTIMONY TO THE HIT POLICY COMMITTEE MEANINGFUL USE WORKGROUP

Ohio Health Information Partnership

May 13, 2011

Good afternoon Mr. Chairman, members of the committee, and esteemed guests. I want to thank you for this opportunity to report on our REC, the Ohio Health Information Partnership – OHIP – and the work we are doing as a Regional Extension Center in the state of Ohio. As the state designated entity for HIE development, we also want to report on our progress in health information exchange. OHIP's region stretches over 77 counties in Ohio. We act as the umbrella organization for seven regional RECs situated around Ohio that provide the local presence for the physicians and hospitals. Our regional partners have more than dozen consultants working with physician practices around the state. Our goal is to serve 6,000 PPCPs in Ohio and we are almost two-thirds of the way there.

### I. OHIP Implementation Model

OHIP has created a new model for physician adoption of EHR, using tools that can bring more structure and consistency to the process than has been seen in the past. OHIP has partnered with Welch Allyn to develop an online tool that standardizes the approach to workflow assessment and assists practices in analyzing the business decisions that go into selecting an EHR. In addition, OHIP has partnered with the Ohio State Medical Association to develop a Performance Improvement CME (PI-CME) that offers 20 Category 1 CME credits for physicians that move from paper to Meaningful Use. The program is available to any physician nationally who wants to use

his/her EHR adoption as the backbone for the CME credits necessary for specialty certification and license renewal requirements.

## II. Coordination with Other Federal Programs

OHIP has worked closely with many other federal programs to support the REC's efforts in the most efficient and complete method possible -- from the Area Health Education Centers (AHECs), which have developed some of our marketing and outreach materials, to the HIT workforce programs in four of Ohio's community colleges. These programs are retraining clinical and IT personnel to provide the support necessary for vendors, hospitals and physicians in an electronic era. We are also blending the development of the statewide HIE with the work of the REC, using the opportunities afforded to go from community to community and use the hospitals as the hub for HIE development, thus setting the stage for connecting the surrounding physician community. OHIP's approach has been to work as much as possible with communities, allowing each unique community to dictate the terms of HIT development and clinical data sharing within their healthcare area.

## III. Stories from the Front

Once physicians get past their suspicion that the REC is too good to be true -- since in Ohio we do not charge PPCPs for REC services -- they have turned to us to answer questions and unravel many problems that occurred when they did it themselves. We have numerous instances where our REC consultants worked with practices that had already "implemented" but continued to have ongoing problems due to lack of vendor support, lack of initial training for the physicians and staff, and a poor assessment of the EHR product and the practice's needs.

## Examples of the RECs value to a practice:

- The Little Flower family practice in Canton, Ohio, spent a year trying to vet vendors with no success until the practice signed with the REC in Akron. With the Welch Allyn tool to assess the practice's workflow and needs, within weeks the practice had selected a vendor. The contract that OHIP had negotiated with the EHR vendor covered every potential issue and the physician's attorney was more than happy to sign off. Little Flower was also able to use the EHR loan program – established by OHIP with four of the largest banks in Ohio to obtain below market financing for their EHR system. In addition, the REC director assisted the practice in selecting one of Ohio's preferred EHR vendors, making a perfect fit for this small practice. The practice is now in the process of receiving training prior to going live in July.
- A 6-person pediatric practice discovered that its EHR vendor was planning to sunset their EHR system rather than seek ATCB certification. This left the practice scrambling to demo new EHR products and at the same time, to attempt to manage the patient data conversion from the old system to the new. By signing up for REC services in Cleveland, the practice was able to quickly go through structured workflow analysis, which enabled them to have the vendor demos scripted to focus on their particular needs. These needs included not only standard pediatric functions such as immunizations and growth charts, but also the internal messaging, patient forms, remote EMR access and patient portal functions specific to this practice's work. In the meantime, the REC consultant was able to arrange for comprehensive data conversion services by an outside IT company that substantially reduced data conversion charges by many thousands of dollars, even while increasing the amount of information they were able to bring forward from their old system. The

practice is currently in the final stages of contract negotiations with their two finalists.

- A practice had purchased an EHR system, but during a reorganization, the vendor had fired most of the experienced training and support staff and hired inexperienced people in their place. The new training staff could not assist the practice in Go Live nor could they establish the workflow needed to support electronic records and Meaningful Use. The practice was sure they were going to need to purchase a new system and lose the tens of thousands of dollars already expended. The REC administrator, an experienced healthcare IT person, went into the practice and was able to train the staff and meet their IT needs to allow them to successfully implement the already purchased system.

#### IV. Meeting Meaningful Use

At this time, I would like to move into a discussion of issues we have seen from the field with meaningful use.

##### A. Issues for Physicians

- The largest ongoing issue is e-prescribing, both for current electronic practices and those that have not adopted at all. The lack of coordination between the MIPPA incentives and the HITECH incentives has created ongoing confusion and has diverted the work of the consultants in getting practices to adopt certified systems and meet meaningful use. It is creating a shell game to meet these criteria using systems that will then be removed and replaced by an EHR system. The problems are numerous:
  - 1) Physicians that meet the letter of the law in 2011, but not the administrative CMS regulations, will still lose 1 percent of their Medicare reimbursement in 2012. Specifically, if a physician adopts an EHR system in the second half of 2011 and meets the

CMS guideline for e-prescribing by the end of the year (the MIPPA standards), he or she will still lose 1 percent of their Medicare reimbursement if they did not submit 10 Medicare prescriptions electronically by June 30, 2011. There is no appeal mechanism or system set up to review whether a practice has met the MIPPA e-prescribe requirements, therefore, there is no mechanism to reverse the 1 percent reduction in Medicare reimbursement.

Let me give an example of how this is affecting patient care and the quality of medical practice: nursing homes in Ohio are by and large not on certified pharmacy systems. Most administer their drugs through institutional pharmacies, having treating physicians send prescriptions to the long-term care pharmacy, then dispense them to the patients. One of the family practice groups in Ohio handles long-term care patients as their exclusive patient base. Since the long-term care facility's pharmacy is unable to receive electronic prescriptions, the physicians have taken to sending at least 10 of their e-prescriptions to the local private pharmacy in the community, then having the pharmacy courier the prescriptions back to the long-term care facility. This is being done strictly to meet the MIPPA requirement of electronically prescribing by June 30<sup>th</sup> to avoid losing 1 percent of Medicare reimbursement next year. Thus, because of this program, the prescriptions are filled at the greatest expense both to Medicare and to the long-term care facility with the least regard for the patients' needs, all because of administrative regulations.

- 2) Core Measure 4: 40 percent e-prescribing. Some long-time e-prescribers that have a high number of patients using mail order pharmacies are having trouble meeting the 40 percent requirement for e-prescribe. This is due to system error with some of the mail order pharmacies that has not been corrected yet. Because of the inability of the physicians to successfully transmit to the mail order pharmacy, they print out the prescription and

hand it to the patient, thus removing this prescription from the numerator of the MU criteria for e-prescribe. OHIP has an e-Prescribe Committee working with Sure Scripts, Express Scripts, the Ohio Board of Pharmacy and numerous hospital and private pharmacists plus physicians. This group is trying to determine what can be done to address this issue so that the mail order pharmacies can reach out to the affected physicians and correct the problem. Until this is resolved, though, it will continue to affect the physician's ability to meet this MU measure.

3) Surgeons who write prescriptions for controlled substances for pain post-surgery still must meet the MIPPA e-prescribe standards (whether or not they have adopted an EHR system), even though virtually all of their prescriptions are ones that do not qualify for e-prescribing. The surgical practices would rather coordinate the e-prescribe feature with the adoption of an integrated EHR system than have to install a modular e-prescribe system just to meet MIPPA timelines.

- Core Measure 10: Report Ambulatory Clinical Quality Measures. The clinical quality measures that have been approved for an ATCB certified system may not be the ones that a given specialty wants to submit as the CQM that most closely fits the needs of their practice. Because many vendors have only obtained certification for a few CQM, it is unclear whether the CQM submission will come from a "certified" system if the system is updated after the fact.
- Measures Requiring a Change in Protocol: Those measures that require more support staff involvement with new issues (e.g., patient education, recording of smoking status, recording of obesity) are taking longer to implement since there is a more radical change in workflow involved with these measures.

## B. Issues for Hospitals

- Core Measure 3: Maintain an up-to-date problem list. The use of the problem list in the inpatient setting at the 80 percent level. Many physicians are hesitant to accept ownership of the problem list unless they are “captain of the care” so some patients do not get a problem added. In addition, many doctors in an inpatient setting are also looking for this to be more diagnosis related rather than general problems, so it is taking a great deal of education.
- Core Measure 12: Electronic Copy of Health Information. The hospitals have raised the question about whether in the release of patient records, they need to make the records “human readable,” i.e., to create some type of explanation of the more technical terms used in the data released to the patient. If information needs to be “translated,” at what level do the results need to be explained? There is a definite concern about the amount of manpower it will take to make records human readable.
- Timing of Stage 2 Adoption: Hospitals are seriously discussing not attesting to MU in 2011 merely to avoid having to meet Stage 2 MU in 2012. They are concerned that there will be less time to implement the changes necessary for Stage 2 than if they waited another year to attest to MU.
- Ability of State Health Department to Accept Immunization Data and Syndromic Surveillance Data. OHIP, as the state designated HIE, is working with the Ohio Department of Health to develop this reporting capability.

## V. Recommendations

- Slow down. Do not require CQM actual reporting until 2013 to allow the vendors a chance to have their systems certified for most, if not all, the CQM measures. In this way, practices can report on the measures that actually reflect what their specialty would normally track instead of what the vendor has selected.
- Hold in abeyance the MIPPA e-prescribe standards to the extent that they conflict with the HITECH incentive programs.