

**Response to Provider Questions for HIT Policy Committee
Meaningful Use Workgroup
By
Jennifer Bolduc, MD
CMIO, Walla Walla Clinic
September 25th, 2011**

Commentary

Dr. Tang and members of the Meaningful Use Workgroup, my name is Dr. Jennifer Bolduc and. I am a pediatrician and CMIO of Walla Walla Clinic. Walla Walla Clinic is a physician-owned multi-specialty group with approximately 50 providers practicing out of 4 locations in southeastern Washington and northeastern Oregon. I also have the privilege of participating in the Executive Forum for our EHR vendor.

A number of Executive Forum members have shared their responses to your questions with me. In this commentary, I will summarize our collective answers as concisely as possible, thereby representing small multi-specialty groups, large hospital systems as well as teaching hospitals.

Overall, there has been a significant investment of money and human resources to achieve Stage 1 of Meaningful Use. Many of my colleagues report a \$500,000 to \$1,000,000 price tag. The majority are aiming for 2011 attestation via Medicare. Universally, we have found that Meaningful Use has taken over our strategic planning.

Our collective experience for Stage 1 of Meaningful Use has shown that e-prescribing and those measures that can be set for the entire system by IT are the easiest to achieve. Clinical summaries are the most problematic for almost all of us for various reasons including lack of patient interest, excessive printing, and concerns about potential HIPAA violations. We feel that the need for a printed or electronic clinical summary should be dictated by the patient. The timeframe for releasing lab results and the complexities of medication reconciliation have been challenging for several organizations. Reporting expectations and negotiating exchange of information with other organizations have introduced another level of difficulty, often because we are dependent on vendors or other healthcare providers who are struggling to keep up with Meaningful Use requirements.

Of the remaining questions, there were frequent comments about the care team concept and HIEs. While the value of a list of care team members is seen as positive by many forum members, the usability of the list was questioned. The same holds true for HIEs. We all see the need to connect meaningfully with other organizations, but have little confidence that the industry can support this endeavor at this time.

I found it very interesting that the group was decidedly neutral regarding the reaction of patients to Meaningful Use. In my own practice, I have had many patients and their parents comment on the transparency. They often say "Dr. Jen, we trusted you before, but now that we can see the record, we really believe you". The new tool of our trade, our EHR, can make a huge educational impact as well. Many of my adolescent patients now ask to see their plotted BMI as part of every visit. Not only do they understand what it is, but when we look at it together, I have found that many of them have actually responded to the previous BMI discussion and have lost weight. The joy and pride on their faces make it all worthwhile.

What is the experience of EPs and EHS in implementing meaningful use in the field, and how can that inform meaningful use in Stages 2 and 3?

In general, the implementation of Stage 1 of Meaningful Use aligned with our previously established organizational goals of EHR implementation, although it moved us much faster than our money, human resources and culture expected. The prospect of moving forward into Stages 2 and 3 is daunting as we are still catching our breath from Stage 1.

The Power of Patient Engagement

My patients often say “Dr. Jen, we trusted you before, but now that we can see the record, we really believe you”.

The new tool of our trade, our EHR, can make a huge educational impact as well. Many of my adolescent patients now ask to see their plotted BMI as part of every visit.

Not only do they understand what it is, but when we look at it together, I have found that many of them have actually responded to the previous BMI discussion and have lost weight.

The joy and pride on their faces make it all worthwhile.

Experience with Meaningful Use:

Do you plan to apply for reimbursement for Meaningful Use of HIT via Medicare or Medicaid?

Walla Walla Clinic pediatricians, including myself, have all successfully attested to Washington Medicaid. Unfortunately, we could only attest to the upgrade level, although we were ready to attest at the Meaningful Use level. We have one internist who has successfully attested to Medicare with many other providers engaged in the process.

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

The pediatricians used the last quarter of 2010 per Washington State’s requirements. For those pursuing the Medicare incentive, we started in May 2011 with our first provider. Now that we understand the process, we are proceeding with more providers on an individual basis.

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

The easiest objectives to meet are those that allow for a setting to be fixed for the entire clinic, for example the drug-drug interaction alert. The next easiest are those measures that can be accomplished by support staff, for example, demographics are entered by our reception team and nurses are responsible for vital signs and medication allergies.

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

We have found, to our great surprise and delight, that almost all of the core objectives are met easily within the usual documentation workflow as long as the provider is comfortable using the system. However, reporting is limited to the data we capture electronically, so if providers are using paper prescriptions, we have no way to track this data. Our ideal solution for this would be for pharmacies to only accept electronic prescriptions. Given how successful and safe electronic prescribing has been, this would be a reasonable path to pursue.

The most problematic objective in our organization has been the clinical summary. Our physicians have balked at printing a summary for two reasons. One, they all complain about the waste of paper and question the use of an electronic system that requires them to print. Two, patients frequently leave these papers in various trash receptacles or in the parking lot thus raising HIPAA concerns. Our preference is to push this to the patient portal upon patient request.

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

Any objective that requires the interaction of more than one vendor instantly doubles the time for implementation. For instance, installing the lab system required three vendors (lab, EHR & practice management) and ourselves to meet the structured lab data objective. Managing the complexities of this interaction was a significant challenge for our small group in terms of time, cost and frustration, from the lack of control we had over the process.

Working with the state regarding immunization registries is a variation on this theme as well. In particular, our state has requirements that are above and beyond what is required in other states, which has been problematic for our EHR vendor and has therefore been problematic for us.

To echo what I mentioned above for the core objectives, reporting would be more reliable if pharmacies, labs and imaging centers would only accept electronic orders.

“4 years ago, my rudimentary computer skills broke almost every computer I tried to use for my one and only application, email. Even my friends knew to email my husband if they wanted a response. As you can imagine, I was intimidated and skeptical regarding the use of an EHR and now, I have this amazing opportunity to share my experience of moving our clinic toward Meaningful Use”

**Jennifer Bolduc, MD
CMIO, Walla Walla Clinic**

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?

Our clinic has never had any capability to report on clinical quality prior to meaningful use. Every provider that I educate regarding meaningful use has been excited to have this information available to them.

We had the honor of beta-testing the clinical quality tool for our vendor. This perspective has led me to appreciate the tremendous work required to generate reports that accurately reflect the clinic work being done. While we can generate a report, I see that we will be putting in some very long hours to provide reliable and reproducible reports.

Has the EHR certification program made it easier for you to report on the meaningful use quality measures?

If our vendor had not been required to provide reporting capability, we would not have had a chance at meaningful use at all. The prospect of purchasing a 3rd party reporting solution and perform all the associated database mapping and alignment with workflow would have been impossible for our clinic.

What have been the major challenges, especially external factors (links to other organizations, vendor issues, etc.)?

1. **Money** - We are a physician-owned group without hospital support. Every dollar comes from physician and employee pockets. Also, our for-profit status disqualifies us from all the grants we have found.
2. **Resources** - This really comes back to money as we are fortunate to have found capable and dedicated employees in our rural area.
3. **Rural Health** - Many of our providers participate in Rural Health and those Medicare charges are excluded from meaningful use due to a problem with bundled payments.
4. **Other issues** with vendors and the state have been cited above.
5. **CMS web site access** - Registration and attestation for the incentive payments is straightforward, but accessing the site fails 75% of the time.

<p style="text-align: center;">Major Challenges</p> <ol style="list-style-type: none">1. Money2. Resources3. Rural Health4. Vendor/State issues5. CMS web site access
--

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

From a financial perspective, we have benefitted from our early-validator status, so the cost of the meaningful use upgrade has not been overwhelming. However, the strain on our human resources has been significant. We have had to spend a significant amount of time understanding Meaningful Use, and in particular, reporting, as this was completely new to us. The same staff has then had to stretch even further to provide education to the rest of the organization.

Looking at proposed Stage 2 objectives, please comment on the proposals to develop a list of “care team” members and create more virtual communication among those providing services to each patient.

<p style="text-align: center;">Key Points for Care Team List</p> <ol style="list-style-type: none">1. Physician data entry not required2. Patient input to confirm/deny via portal3. Care Teams are listed as active or inactive4. Multiple Care Team elements needed

A list of care team members could be valuable depending on the structure. My requirements for this would be:

1. Physicians are not responsible for data entry.
2. The patient can confirm or deny the content of the list via a patient portal.
3. Care Teams are listed as active or inactive with regard to involvement in care and organized by specialty.

4. There would be a care team element in the medical record that contains multiple items.
 - a. Care team member demographics that would include a preferred communication method and the ability to initiate contact by clicking on it or touching it, something like right-clicking on an email address and being able to start a new email. Demographics would also include specialty and location.
 - b. Active or inactive status of the care team member- a sub-specialist should be able to sign off on care and become inactive or reactivate as needed. This would also include a date last seen.
 - c. Due date for follow up with the care team member to be built in as a reminder or alert.
 - d. Care teams are very different in the hospital setting versus the outpatient setting, so a division may be appropriate there.

Looking at the proposed framework for Stage 2 quality measurement, and the “measure concepts” that ONC and CMS are encouraging for Stage 3, how do you assess the value of those measures to your organization, and the ease/difficulty of collecting and reporting them?

Many of the proposed measures for Stage 2 as well as many of the measure concepts will likely be viewed as clinically helpful, such as appropriateness of medications and imaging.

However, other measures will require a significant culture change in order for our providers to become comfortable. One example of this is a patient’s access to the provider through online messaging. Many are currently struggling with the concept of the patient portal, in spite of knowing that patients already have access to their medical records, so direct online communication is viewed as threatening.

In reviewing the upcoming measures, I am concerned about the amount of education and culture change that will be required for both population health and care coordination. Our organization has very little experience with either of these and I am apprehensive about our lack of resources. In addition to our lack of experience, we will be placed in the position of coordinating care and exchanging information with hospitals and the state, who do not yet have the systems in place to make this possible.

In summary, measures that are an extension of what we are already doing for Stage 1 are not problematic. However, measures that will require further culture change, extensive education and reliance on organizations outside of our control all pose significant obstacles.

Issues moving to Stage 3

1. Significant Culture Change needed
2. Incorporation of patient on line messaging into provider workflow
3. Significant education and culture change that will be required for both population health and care coordination

Please comment on the value of introducing quality measures that require data to be assembled across multiple settings or over time – such as patient-reported measures, delta measures that compare an indicator at time one vs. time two, or those that require linkages between clinical and claims data. For such measures, please comment on your interest in HIEs, registries, or other data integration partners.

I'm hoping that this question is pointing in the direction of the one patient-one record concept. This would absolutely require data to be assembled from multiple settings over time and require participation from everyone involved in the patient's care, including the patient. Data validation, common languages, and bidirectional flow of information will be necessary for data integration partners to be successful in this. This is an ambitious goal, but along with clinical decision support, could provide the provider-patient team with the tools to make the best choices possible.

How have your patients reacted to your efforts to qualify for meaningful use; have they used the functions designed to increase patient engagement?

My patients have responded very positively to our use of technology, but aren't specifically commenting on it as part of meaningful use.

Of the positives, certainly the use of electronic prescribing has been convenient and comforting to patients. I have found that sharing the medical record on a large flat screen TV to be a huge win with patients as they appreciate and trust the transparency. I'm looking forward to our implementation of our patient portal to increase patient engagement.

The negatives have revolved around collecting race and ethnicity. Some patients are very resistant to those questions and feel that it is none of our business. Lastly, patients don't want the clinical summaries as I mentioned above.

What objectives in MU Stage 3 would help you achieve the goals of accountable care?

We have given much thought to the journey of supporting defined goals outlined in the Meaningful Use Health Outcomes Policy Priorities:

- Improve quality, safety, & efficiency
- Engage patients & their families
- Improve care coordination
- Improve population and public health; reduce disparities
- Ensure privacy and security protections

After collaborating with my colleagues, and in the spirit of Meaningful Use, we offer the 8 objectives highlighted above for consideration if we are to achieve the Ultimate vision, enable significant and measurable improvements in population health, and achieve accountable care through a transformed health care delivery system.

Stage 3 Measures Supporting Goals of Accountable Care

1. The ability to find our high-risk patients (generate patient lists)
2. The ability to generate reminders and alerts.
3. All objectives that lead to the generation of discrete data that can be reported upon.
4. Appropriate Clinical quality measures to the specialty
5. Patient's ability to upload data to the EHR.
6. HIE testing.
7. List of care team members
8. Longitudinal care plans.

How has your work on Meaningful Use affected your organization's other strategic initiatives? Has it caused you to postpone other strategic initiatives? If so, which initiatives were postponed and how does your organization judge the relative merits of the tradeoffs caused by the shift in priorities?

Stage 1 of Meaningful Use validated our strategic initiative to make the most of our investment in the EHR for our providers and patients. This project has stretched our resources to the limit and we have neither funding nor human resources available for anything else. The combination of Meaningful Use, ICD-10 and the anticipated shift to some version of pay-for-value care has provided us with a longer list of strategic initiatives than we ever thought we would encounter, particularly with the added stress of declining reimbursements. That being said, if we hadn't started down the Meaningful Use path, then we would have no ability to move forward with these next steps.