
Testimony to the Meaningful Use Workgroup
HIT Policy Committee

Meaningful Use Stage 3 Hearing
Panel 2: Providers Working Toward Meaningful Use Stage 3

October 5, 2011

Tom Smith
Chief Information Officer NorthShore
University HealthSystem Evanston,
Illinois

My name is Tom Smith and I am the CIO of NorthShore University HealthSystem, (NorthShore) an integrated delivery network in the northern suburbs of Chicago. Thank you for the opportunity to speak to your Workgroup about our progress to date in Meaningful Use, and our thoughts about future Stages.

NorthShore has had some success in implementing our electronic medical record (EMR) and other related systems. We have been essentially paperless in both our hospitals and employed offices since 2003. We now have 4 hospitals, 800+ employed physicians and 80+ independent physicians live on one system and a common data base, representing a longitudinal patient data repository and system used by all departments from the Emergency Departments, inpatient floors operating rooms and physician offices. We have almost 150,000 patients active on our patient portal and this December we will add Home Health and Hospice Care to our EMR.

We did attest for Meaningful Use for both hospitals and physicians (employed and independent) on day one.

While I have submitted this testimony, several other NorthShore staff contributed to its content.

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?

- *Experience with Meaningful Use:*
- *Do you plan to apply for reimbursement for Meaningful Use of HIT via Medicare or Medicaid?*
 - Medicare; we are now reviewing the recently issued Illinois Medicaid plan.

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

- Started January 2011, Attested 4/18/2011; received payments on first day; have received all Year 1 payments expected

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

Detailed List of Objectives We Found Easy to Meet/Exceed

- Attestation-type metrics are more clear than metrics with measurements
- Use CPOE for all orders.

- Implement drug-drug, drug-allergy, drug-formulary checks.
- Maintain an up-to-date and accurate problem list.
- Generate and transmit permissible prescriptions electronically.
- Maintain an active medication allergy list.
- Record demographics: language, insurance type, gender, race, ethnicity.
- Record vitals,: Height, weight, BP and Calculate/Display BMI.
- Record Smoking Status
- Incorporate lab-test results into EHR as structured data.
- Implement one clinical decision rule relevant to specialty or high clinical priority.
 - a) VTE screen/prophylaxis
 - b) MRSA screen
 - c) Pneumococcal vaccination
- Provide access to patient-specific education resources. We utilize MyChart, Clinical Reference, EMMI.
- Capability to exchange key clinical information (e.g. Problem List, allergies, test results), among providers of care and patient authorized entities electronically. Internally this is transparent- one record.
- Perform medication reconciliation at relevant encounters and each transition of care. Inpatient – Med Rec navigator facilitates process. Able to accomplish. Monitoring compliance accomplished by accomplishing discharge med reconciliation navigator. Ambulatory encounter med reconciliation attested to by "Reviewed" button on med list, and inclusion of med list on After Visit Summary (AVS).
- Compliance with HIPAA Privacy and Security rules. Able to audit and report but labor intensive.

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

- The most difficult core objectives to meet are related to providing an electronic copy of health information and discharge instructions; due to impacting all areas of workflow, new implementation of our EMR software Release of Information module, and behavioral changes. The two were more than 50% of all patients who request an electronic copy of their health information are provided it within 3 business days, and more than 50% of all patients who are discharged and who request an electronic copy of the discharge instructions are provided it.
- The objectives (and measures) requiring attestation to collect the data without a specific threshold identified provide an interesting operational scenario in that our organization's culture drives us to improve performance but there is no MU incentive to do so with Stage 1.

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

- Send reminders to patients per patient preference for preventive/follow up care. We can send bulk notification to patients through Clinical Data Warehouse reporting and considerable human interaction. The challenge is to report and remind per patient / per practice / per MD tool for this function.
- Generate lists of patients by specific conditions to use for quality improvements, reduction of disparities and outreach. This can be done retrospectively with queries in our Clinical Data Warehouse, but need patient panel management tools per physician or practice through broader deployment of Reporting Workbench.
- Capability to submit electronic data to immunization registries and actual submission where required and accepted. Capability exists, but no receiving agency at this time. They are still working out internal challenges to accommodate submissions.
- Capability to submit electronic surveillance data to public health agencies and actual transmission according to applicable law and practice. No standard definition of what to send or receiving agency capable of electronic receipt at this time.

- Record advanced directives for pts 65 old or older: Application did not present a user friendly workflow for capturing this at point of care.
- Receives patient from another setting of care or provider of care and believes an encounter is relevant should perform medication reconciliation: We did not implement because we do not have consistent medication reconciliation responsibilities or workflows defined across the organization. We did however focus on medication reconciliation so that our discharge instructions were complete.
- Ability to exchange health information with external clinical entities. State of Illinois HIE is not yet operational. We demonstrated this exchange through our vendor software with several other users.

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?

- The quality measures pose their challenges in the form of definition -clarifying inclusion and exclusion criteria to ensure we capture the correct patients.
- We would like MU quality measures to align with other initiatives, so that duplicate initiatives and reporting were not necessary. See our comments for the last two questions for more comment on this.
- The measures which are primary care oriented worked well and satisfied attestation requirements for the majority of our physicians. We chose not to build out all 44 EP measures because the workload to build and report would have been too difficult to produce in the timeframe we set for attestation. Additionally, the workflows that would have needed to be put in place would have added another layer of complexity to meeting all 44 measures.
- We selected quality measures that we did not have to adjust application build or workflows to meet Cervical Cancer screening, Breast Cancer screening, Colorectal Cancer screening.
- The selection of the Quality Measures is very appropriate as these are not new to organizations, however the reporting has been quite challenging not only from an internal organizational workflow standpoint, but from discrepancies between CMS standards, The Joint Commission, and contemporary practice. This will need to be addressed before reporting results of these quality measures should occur. Again, see our comments for the last two questions for more comment on this.

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

- It has required us to change workflows and successful processes that have been in place for years in order to fit the report structure from our vendor. We expect that this will evolve over time however; for the period of the three Meaningful Use stages it is very likely that certified EHR vendors will develop reports with limited flexibility in how we capture data. The alternative of certifying our own reporting process also creates additional work.
- Our EMR vendor has been CCHIT certified for some time and has produced the reports that allow compliant reporting, as long as our configuration adheres to the data structure and vocabulary of the vendor's Model System.

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

- External entities like Illinois Department of Public Health were not ready to accept more than test data.
- We spent the vast majority of our time on producing reports. The logic of using a Certified EMR for our patient care is more than reasonable but if the data could have been moved to our data warehouse in some cases we could have reported more quickly. Reporting large amounts of retrospective data is not a strong point of most EMRs.
- We have experienced many issues with the attestation website-slowness and loss of connection. This began in late June when the website internet service provider was changed from AT&T to Verizon and still has not been fully resolved. Because of these issues, the time to complete an individual attestation has doubled.

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

- We estimated our work effort for Stage 1 Year 1 to be 36000 man hours. Projects that we postponed to concentrate on Meaningful Use were primarily the optimization of our EMR content, and active recruitment / deployment to our community physicians.
- Approximately 70% of these hours were spent on getting reports correct; not improving quality.

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.

- Success of meeting this objective will be dependent on a standard definition of what constitutes a "care team". Clarification of virtual optimization appears to assume everyone is using the same EMR.

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?

- The measure concepts have high value and ones we have been pursuing independently of MU. Our focus on this has been diverted somewhat by the challenges experienced with required reporting. While the economic incentive to meet these measures is a good initiator, the success of obtaining these measures will need to be driven by an aspiration for better quality.
- NPP quality measures related to patient and family engagement. It will be difficult to judge the value of this based on voluntary participation from the patient and family. While we have the capability to communicate and engage; many/most patients are not active in the participation of their care and may not take advantage, given the opportunity.
- Aggregated clinical summaries from multiple sources available to authorized users is a great concept but susceptible to incorrect information being recorded and retrieved when coming from multiple sources. Many organizations have successfully created a community for their patients within their hospital or health system. The need to share data across counties, states, or regions is not yet as compelling. Defining and identifying the 'source of truth' will be challenging.

- NQF endorsed Care Coordination measures. These will have better value if they are embedded into a health system's EMR so that it is an intuitive process. Recommend a national consensus or mandate for readable discrete coded information that can be easily incorporated into an EMR.

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.

- In order to compare our quality performance against best practices throughout the country, this will be an important step in improving quality both at the organization and physician level. Certain vendors already have this information available (ex. 3M, Crimson) for benchmarking but obtaining this information for the provider level will allow organizations to do their own data analytics. We also agree that patient reported measures are becoming more important (ex. blood pressures collected from home) and reliable vs. what might be reported (potentially elevated blood pressure) while in the office.
- We are interested in HIE type functionality to meet these needs but are waiting to see if HIEs will be sustainable. In the meantime we are using other methods for clinical data integration. The patient and the caregiver should be able to easily obtain and see data over time. Integrating data from multiple sources must be efficient, standard, and simple. In order to achieve successful information sharing across multiple repositories, a standard communication language that all participants adhere to is a must.

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

- We have had a very active patient portal since 2004 so patients have had online access for some time to their health information. Our patients' response to our portal has been very favorable. They prefer this method to access their information and communications so it would be ideal if this access could count toward the objective of release of electronic records to patients who request them. The patients' use of our online portal has reduced our internally requested information to a very small number. Because of this low "n" we are at risk at not meeting this core objective.

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

1. Development and utilization of a universal patient identifier.
2. Assist in harmonization of measures.
 - The difficulty comes about in managing the number of reporting requirements from The Joint Commission, State and Federal agencies.
 - There are at least 3 final rules within the last 2 years from CMS that specify the current requirements to meet for the annual payment update which should be harmonized with the Meaningful Use stages.
 1. Inpatient quality reporting (IQR)
 2. VBP
 3. Readmission reduction
 - On top of these, the ACO reporting requirements were released with no cross walk for hospitals/providers. We are left to construct tables of where the measures intersect, though with caution as the definitions may

have slight nuances and variations. Given this, the crosswalk has limited use. The work of meeting the payment updates is duplicative of Meaningful Use.

- The end goal should be identified for each high risk condition and require reporting not in a collection of singular indicators but composites that would assist us in caring for these patients.

Here is an example using CHF:

- Reduction in readmission (Separate CMS program) (derived from claims data) given to us in a number that has no associated clinical meaning. We are scored as higher or lower than expected.
 - CHF abstraction for core measures (core measures program)
 - Discharge instructions, medication reconciliation, PQRI measures for MU, patient education.
 - ACO: 30 Day post discharge visit (too late to do any good for management of new onset or fragile patients; admissions (count); cholesterol management; BP measurement; duplicative measures of core measures for "at risk patients" etc.
 - ACO: All or nothing scoring on core measures which means that if we miss one core measure in the bundle for one patient we get no credit. We have never looked at data like this. The current core measure reporting measures each indicator across a population rather than at the patient level. This is in conflict with other federal programs.
 - Scattered measures related to medication reconciliation, medication lists, drug-drug interactions and CPOE. Put them all into one bundle.
 - Patient satisfaction: we follow the prescribed process but this is after discharge so we cannot affect care and the scores do not single out e.g., CHF patients, and how they feel about their experience.
- We realize that you need to track all of our efforts but given the costs of the chronic diseases, it would seem that some effort to focus MU on these patient in Stage 3 would be useful and fit better with how most healthcare organizations are trying to measure and improve their quality.

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?

- We have supported Meaningful Use as a set of measures that are all good things for us to do for our patients and clinicians. The Meaningful Use process has been a positive force within our organization to focus on quality improvement and measurement. Even with that said, there have been concerns.
- We have the good fortune to be well along the evolution to a patient-focused, community-based, longitudinal health record and are aggressively expanding our employed physician group deploying to community physicians while optimizing our process and platform. Meaningful Use efforts were somewhat distracting and slowed our process for deployment, process improvement, and quality enhancement/reporting. The money is useful, but caused a re-focusing of considerable resources. This is true both at the customer-user level, as well at the vendor level.
- The system should be designed with the end in mind. For high risk patient populations an organization should be able to look across all federal reporting requirements in ONE place to assess performance on the longitudinal management of patients from ambulatory visits, prevention of readmissions, home care (in its infancy and very important, patient surveys (do them before discharge and not post discharge). The same group of indicators should meet The Joint Commission requirements and CMS. We need to take the time back from managing measurement and reporting and put this into the bedside for improving care and education of our patients and families. Today we are left to develop our own tools after the laborious measurement and abstraction to connect the dots.