

# Meaningful Use Workgroup Hearing

October 5, 2011

9:00 a.m. to 4:15 p.m./Eastern Time  
Washington Marriott at Metro Center  
775 12<sup>th</sup> Street, NW, Washington, DC

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## Instructions and Questions for Panelists

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### Background

Testimony from this hearing will help the Meaningful Use Workgroup (Workgroup) inform their deliberations on Stage 3 Meaningful Use objectives, and eventually formulate recommendations to the HIT Policy Committee and the National Coordinator on Meaningful Use Stage 3. Overall, the Workgroup is seeking a sense of common enablers to overcome key barriers to Meaningful Use. They are looking to the future – what should be contained in MU3-certified EHRs to help deliver accountable care as well as discover lessons from MU1. If you have questions, please contact Paul Tang, Chair of the Workgroup, or George Hripcsak, Co-Chair, [paultang@stanford.edu](mailto:paultang@stanford.edu) or [Hripcsak@columbia.edu](mailto:Hripcsak@columbia.edu)

### Format of Presentation:

The Workgroup respectfully requests that panelists limit their prepared remarks to **five (5) minutes**. This will allow the Workgroup to ask questions of the panelists and allow every presenter time to present his or her remarks. We have found that this creates a conversation for a full understanding of the issue. Given the large number of questions, please select three topics to comment on in your oral remarks. You may submit as much detailed written testimony as you would like, and the Workgroup members will have reviewed this material in detail before the hearing. PowerPoints will not be needed.

### Pre-Presentation Questions/Themes:

The questions below represent areas the Workgroup intends to explore at the hearing. Please feel free to use them in preparing your oral and written testimony; the Workgroup recognizes that certain questions may not apply to all presenters.

The Workgroup respectfully requests panelists to provide written testimony no later than **September 26, 2011**. Please submit the testimony to Josh Seidman and Judy Sparrow at [josh.seidman@hhs.gov](mailto:josh.seidman@hhs.gov) and [Judy.sparrow@hhs.gov](mailto:Judy.sparrow@hhs.gov)

## Presenter Biography

In addition, the Workgroup requests that all presenters provide a short bio for inclusion in the meeting materials. Please send your short bios to Judy Sparrow, [judy.sparrow@hhs.gov](mailto:judy.sparrow@hhs.gov) ALREADY SENT

## **THEMES/QUESTIONS**

**Panel 1: does not apply**

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

**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?**

First, I want to introduce myself. I am, first, a family doctor of 14 years, practice full-spectrum care for the Federally Qualified Health Centers, Community Health Centers, Inc. in Salt Lake City. I am also the clinician lead for the Utah Beacon Communities Project, IC<sup>3</sup> which is improving diabetes mellitus outcomes using office EHRs and robust quality improvement. My practice implemented eClinicalWorks 1.5 years ago, and we are on the path to Meaningful Use. I myself will attest before the end of the year. I wholeheartedly support Meaningful Use as a framework for helping create a “floor” condition for providers to improve their performance, but see barriers to the rapid change we all desire to see. In my role with IC<sup>3</sup> Beacon at *HealthInsight*, the Medicare Quality Improvement Organization for Utah that also supports the Utah Regional Extension Center, I have a broad view of Stage 1 processes at the office level.

As an organization that houses both a Regional Extension Center as well as a Beacon Community project focusing on a clinical condition (diabetes mellitus), our experience can shed some light on the progressive quality improvement that comes with Stage 2 and 3 Meaningful Use. Our Regional Extension Center has enrolled 759 providers (approx. 131 practices), 8 have attested for Stage 1 and approximately 94 providers will attest by December 31, 2011. The Beacon clinical portion of our project has 66 primary care provider offices in 3 counties, both urban and rural. Of the 66 offices, there are 19 EHR versions being used, all providers are planning to attain Meaningful Use, and are required to submit diabetes quality measures and show improvement in those 8 measures over the 3 year project.

In general, the adoption of the core measures for Meaningful Use has been well received by providers that are working with the Regional Extension Center and Beacon Community. We had a high penetration of EHR use prior to Meaningful Use (over 60% for primary care in our state). Thus, we had an “early adopter” field in many cases. Many providers were interested in the reimbursement as well as the increased functionality of quality measures in their electronic records. In addition, the clinical health information exchange generated interest as it was shared as part of Meaningful Use (connectivity). As we progress through Stages 2 and 3, this interest will be maintained only if (a) good clinical outcomes can be seen by providers as a reward for their hard work; (b) reimbursement continues to be lucrative for providers to participate; or (c) the penalties force participation.

The largest barriers in Stage 1 are vendor-related. The delays in certifications, upgrades that alter functions affecting workflows, inability of providers to obtain quality or Meaningful Use reports despite EHR certification has frustrated providers. There is a wide variation in the performance of the certified EHRs as well as in the quality of technical support received by the

provider offices. For the next Stages, much of the initial core functionality should be worked out, but any areas where vendors are required to build a *new function* have the exact same risk of delay, poor performance, and risk of the Meaningful Use provider reports being nonfunctional or uninformative. Providers will still be waiting for their “upgrade” and have to wade through the bugs and wait on long support call queues to discuss the new software glitches. This is not likely to improve and will test providers’ patience with this process.

In the current market, we are finding that providers that have postponed EHR implementation are at an advantage as they do not have to re-invent their ingrained processes for each upgrade. Instead, they are making one large changeover from paper to an electronic record. That said, once they adopt they become the same as all users of EHRs. As Stages are clarified, they will require upgrades, data standard changes, and they now get in line with all other offices to have their EHR function as the Meaningful Use reports require.

Another area where we can learn from Stage 1 is workflow at the patient care level. The implementation of core measures have resulted in significant changes to provider workflow which is a key area for our Beacon work as well as my practice’s own work. There is a concern that the Stage 1 criteria are not very clinically robust. They merely require that a measure is tracked, not that it meets a standard, and the next Stages, asking for quality decision support reports and actions, will require a whole new re-working of documentation to meet the new standard. This will delay the delivery of actual quality care. Vendors are also not (yet) building their systems for robust clinical measuring, as it is not currently required; it will come in the “next upgrade”.

We do find that our Beacon clinics who report on diabetes mellitus quality measures are pushing harder for meaningful clinical data above the core measures (some can get it, some cannot) and even the choice of quality measures. We find them engaged with vendors at a higher level and anecdotally feel that they are much more in tune with the “big picture” of where Meaningful Use is going. We hope this might translate into a faster transition to Stage 2, and ultimately, to improved care quality.

In my own experience in my personal practice, we are Beacon practice and are currently working toward better blood pressure control for our diabetic patients. We are actively engaged with eClinicalWorks to re-learn how to properly document and verify blood pressures so that we can track our measures through the Meaningful Use report. We are motivated to have baseline data in order to then demonstrate improvement in that measure. We are re-training staff to enter data properly, and we are sharing reports with staff to spur interest in our activity. Beacon participation is causing us to engage at a clinical level that Stage 1 does not require.

We have found that some primary care offices do not understand the value of a patient list or what to do to maximize the patient reminder system. They are not in tune with the reasons for the Stage 1 measures and will have more trouble as Stage 2 dawns.

The patient summary, as a more complex, time-consuming clinical documentation, is one of the most difficult areas for providers. It forces the development of faster documentation habits, may require sending information after a patient leaves, and is often hard to value if a patient or their family is non-English speaking, illiterate, or if the information being reported is cumbersome to make useful at the point of care.

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

Our state does not yet have Medicaid requirements ready as of September 2011. The processes will be in place starting in October 2011. Yes, most practices are finding it valuable to apply for Medicare reimbursement.

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

Many of the basic documentation areas such as smoking, allergies, and vitals are easy. These are standard to workflow and programming for all electronic records and seem to be easy to adopt. If the lab interface is working, this is easy as well.

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

Electronic prescribing has no standard workflow plan at the pharmacy side which has made for much trial and error for meaningful patient care. We have noted there has been no workflow guidance for communities.

Due to the delay of the finalized demographics list standard, vendors were also delayed in providing correct choices to EHRs in upgrades. Often the software solutions provided are not logical to office workflow.

On reporting ambulatory standards, we experience that at this time is not clear how the data will transmit nor how usefully it will be received.

Patient summaries were described above.

With regards to connection to interface, at this time, it remains unclear when or how ongoing connections for our vaccination registries and clinical summaries will be developed and meaningful. Initial tests do not tell us what is realistic.

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

For lab result as structured data, we find many labs are not ready and/or are overloaded with requests and cannot fulfill on this for provider offices.

**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?**

There are many measures that align with quality programs in place, but vendors have not developed or activated many that are germane to practice. For Beacon practices working toward diabetes care improvement, we are finding that often Meaningful Use reports on hypertension control or hemoglobin A1c control quality measures simply do not function and are meaningless for improvement at this time. In my practice we were not getting accurate reporting of hemoglobin A1cs averages despite having in-clinic testing, and longstanding processes that ensure patients are getting tested at 3-6 month intervals. We return to basic entry errors, software glitches, and repeated calls to our vendor. We had an old registry that was less frustrating because despite double entry of data the information was retrievable and reportable. We hope to have this solved soon.

**Has the EHR certification program made it easier for you to report on the Meaningful Use quality measures?**

This completely depends on the EHR vendor; some vendors don't get the importance or functionality and cannot effectively link Meaningful Use measures into their system. For example, we have a system that was certified, yet the providers must still hand calculate their quality measures. We also have a pediatrician that cannot obtain quality measures because he is not reporting Medicare measures, just Medicaid, and his EHR has not built the measures for pediatric care.

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

Vendor variability and speed of HIE development.

**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.**

This is a "good idea", yet the definition of care team is critical. A recommended but flexible protocol is warranted, as well as a delineation of expectations for communication amongst a care team. This is not just a "cc" at the end of a dictated record. Across specialty and institutional lines, medication reconciliation or problem list changes might occur. Communities need to agree on workflow for this information and this represents a non-trivial challenge. We will need robust connectivity through an HIE. It will be important to designate "who is responsible" for the care team and to allow a patient to define and list members of their team.

This is probably too much for Stage 2 to define and implement. Having an expectation for technological ability and allowing providers to develop best use workflows that set standards may be the best first step. We will learn from sharing continuity of care records and transition records electronically, but this is too tall an order for Stage 2.

**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 measure concepts are valuable, but it is incomprehensible, at this time, how the clinical teams will accurately document this, There are clear evidence based data points we can put into an EHR for many of them, and the EHR will be able to meaningfully produce a Clinical Decision Support reminder at the point of care that will intervene to improve outcomes.

**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.**

This area will likely have great value as entities move into Accountable Care Organizations. Particularly in network designed Accountable Care Organizations (ACO)'s vs. economically integrated ACO's. The capability will also likely have great value in a transitional model setting (some business in ACO payment, some business in traditional payment). Having the ability to view this data at a "community" level for benchmark purposes as well as for opportunity assessment purposes will have value.

Robust HIEs are key to this ability, They must integrate useful information with agreed upon community standards. The HIE itself must have a registry function.

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

Patients are largely unaware of Meaningful Use. In most cases, patients seem to favor e-prescribing. In cases where the prescription transfer workflow issues have been worked out, patient recall functions have had positive responses.

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

Interoperable health information exchange (HIE) capabilities will be necessary for accountable care that is organized on a network basis (i.e. virtual and contracted vs. economically integrated).

Entities involved in ACO's will likely not need regulatory encouragement to prioritize and create appropriate data tracking systems. The economic imperative should be sufficient to drive this prioritization effort. The multiple potential dimensions of how "accountable care" may be implemented seems to preclude regulated direction beyond the realm of interoperable HIE.

**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?**

Meaningful Use aligns with the priorities of forward thinking organizations and practices in our state and pushes those that have lagged behind to see the structure (if not the value of) of expectations of comprehensive medical care. In our Beacon practices, many primary care providers are thrilled at the thought of better use of their EHR for quality, and Meaningful Use has been the impetus to investigate the EHR's capability. In many small practices, financial viability is the upmost strategic initiative and the reward for Meaningful Use is a driver, also increasing requests from payers for quality reporting and measurement to increase provider reimbursement aligns with Meaningful Use.

**Panel 3: Does not apply**

**Panel 4: Finding Solutions; Creating Outcomes**

**What are the key data challenges to improving America's health system from the perspective you represent (e.g., quality measure development, certification of healthcare professionals, consumer use of comparison data, coordination of care, payer)?**

We have identified four major challenges that include vendor ability, automation, reporting and patient involvement,

1. Vendor ability to develop the systems we need, connect us, and change with the times.

Complexity and change are two consistent features of medicine. In our Beacon community we have 19 vendors for 66 clinic sites. The vendors are working hard and trying to keep abreast of the changes in Meaningful Use standards as well as the changing standards of medical care,

but in many cases they are behind. As a result, some of our offices lack capabilities that we need and require for Meaningful Use. The timeline for development and attestation deadlines and requirements are not matching.

Provider Meaningful Use reports are poor in some cases . We have providers considering abandoning their electronic records despite significant financial investment. Not only is this very disruptive to patient care, but there is the risk that small providers that provide primary care in small communities will go out of business if they cannot afford to implement another EHR, and they already cannot afford to miss their financial incentives with Meaningful Use.

Some vendors are predicting they will not be able to connect in a timely fashion to health information exchanges. How long should providers have to wait when requirements to connect are already approaching? Providers have done their part to be ready, yet the vendor cannot guarantee a bidirectional interface with the health information exchange.

Finally, if the electronic record can connect, will meaningful information be exchanged? Can we promise our primary care providers that the data elements that are transmitted to their specialist colleagues are intact? Scanned documents are not adequate for true efficient usability, but we are unclear if our care reports are going to actually populate correctly. Actionable data is not easy to perceive in a disorganized lump of data.

## 2. Automation of data collection in workflow

The process for gathering data needs to become automated and built into the workflow of care delivery. Claims-based data have only limited utility for quality measurement. As emerging payment systems rely more upon quality metrics to assure the public that efficiency is not being achieved at the expense of quality, clinical data from EHRs are seen as a key tool. The process of extracting clinical data is very much a manual process today, even with the best EHRs. To the extent the we continue to rely on “extra” effort from providers to gather the data, our ability to assess and improve quality will be limited by the number of measures providers, payers, purchasers, and others are willing to support. Frankly, to have confidence in quality measurement, we need many more measures than we now have, but the cost of such measurement will be prohibitive until we bake measurement into the processes of care delivery itself. Building measurement into clinical care delivery will allow for measures that can be useful for quality improvement and care coordination.

## 3. Reporting standardization

For individual providers there are lots of entities that require reporting. We need to simplify national standards and methods for communication of those standards for insurance companies, national professional bodies, CMS, Medicaid, licensing bodies, and Medical Certification Boards. We need to choose standards that can be addressed at the point of care and in simple processes. If we agree that an area must be addressed, we need to think about the solo rural provider, not just the large integrated practice, as a model for achieving this and paying for it.

The standardization of National and Regional Measures needs to continue to develop. Many providers are still expected to collect data in slightly different formats for different payers, government entities, and community initiatives. This leads to confusion, underperformance, and frustration. The efforts of the National Quality Forum (NQF) and other national initiatives have helped. But they only represent a part of the solution. There needs to be a process to organize

and align measurement and measurement priorities at the community level as well. Chartered Value Exchanges, Regional Health Improvement Collaboratives, Quality Improvement Organizations, State Partnerships, HIEs, and other collaborative processes can all support this goal, if CMS, NQF, and other national entities figure out how to integrate their efforts with regional and local efforts.

In the trenches, a provider needs to develop skill in how to utilize the data, how to improve systems, and how to provide what is needed to patients. With better data exposing provider deficits, how will they improve? Providers need assistance with workflow and best practice dissemination. We need to convene communities to maximize resources for chronic disease management (i.e. shared service models).

As we collect data, we must be aware that there are cases where patients do not fit “standards”. We need a certain percentage of patients to be able to be designated as “at goal for individual health” even if they are not meeting the gold standards set for the population. Individualized care is still valid.

If standards are agreed upon and set by providers nationally or in communities, then quality data can be reported in a standard fashion for the least common denominator and patients. We assert that states should have non-partisan, non-industry supported reports on doctors and health plans. This could be a platform that allows an open dialogue in a community, pushing for quality and mutual understanding of what will improve health. At the individual level, accurate information about a provider’s ability to care for their individual health needs will affect choices of the patient and ultimately health outcomes.

Unfortunately, the tasks associated with shaping the data so they can be actionable by consumers and employers are not yet fully understood. This understanding is essential to the larger vision of engaging consumers in their own health care decisions. Such work is best done at the community level, if well informed by research and best practice models, because national initiatives are unlikely to be able to reach enough consumers or navigate complex political realities associated with public reporting of data. Multi-stakeholder collaboratives are a useful model for this engagement.

#### 4. Patient Involvement

Patients sharing responsibility for the data that represent their health status requires further attention. Developing processes that foster patient interest in the accuracy of their health information will make this more meaningful. Both patient entry of accurate, meaningful health data that is rewarded by their insurer and excellent patient portal workflows can provide better and maybe more economical health care. Like online banking and automatic paycheck deposits, patients have to be encouraged to participate.

**What approaches or solution alternatives (e.g., standards, architectural approaches, workflow changes, policy changes) would you recommend to make the acquisition, analysis, and use of health data more effective and efficient from the perspective you represent?**

Privacy and security laws and rules need to be clearly articulated. Information exchanges are slowed or frozen due to concern over the adequacy of protection from current laws. Some health organizations’ states may interpret their responsibilities conservatively and thus be less

willing to speed connectivity in a regional area. If clear guidance can be made available to support regulatory development in these new areas, it might speed data interchange.

Quality data being generated in our health care system today is too focused on micro-processes and surrogates of outcomes. More attention needs to be paid to (1) outcomes measures (mortality, morbidity, functional status, patient/family experience of care, etc.); (2) composite measures that combine individual metrics and provide a broader assessment of performance at the global- or systems-level for patients, policymakers, payers, and purchasers; and (3) efficiency metrics that include value measurement (cost and quality), which can help consumers understand value in an appropriate context.

Without flexibility in payment for the best care in a community, needed innovation will not occur. Best practices across communities need to be reimbursed, i.e. care managers (remote or on site), virtual visits, portal communication, or shared services models.

Better connectivity to the accounts payable component of practice management systems will allow practices to analyze costs in smaller organizations and leverage improvements that provide good health and keep practices financially healthy.

ONC-ATB certifications need to be standardized and more challenging to attain. Some current certified systems do not guarantee adequate reporting especially with clinical measures. There is too much variation in performance of EHRs with current ONC-ATB certifications. The short time interval to standards for MU stage 1 has caused a rush to certify without sufficient attention to quality output for bedside care.

Vendors need a global data standard on all clinically relevant data elements for information exchanges, CME reporting, state reporting, and eventually ACO data composites. All software needs the ability to connect to this basic set of locales.

### **Specific MU standards to reconsider**

Take off requirement that we use drug formularies and allow the market to drive this. Patients and payers can make this happen.

A requirement for advance directives report in the EHR is on as good as its ability to be shared, this standard should be tied to HIE functionality or community connectivity. Also there needs to be a “discussed but no plan” option for recording the directives discussion without a final plan. End of life discussions take time for some individuals to finalize.

The expectation that the EHR be a patient education repository might be cumbersome to workflow in the office setting. Consider the portal or secure messaging options for patient education and remove the “in office” documentation requirement. This requirement has significantly disrupted workflow as the EHR Documentation of the online education is cumbersome and an add-on in software.

Consider patient engagement expectations, providers must be reimbursed for the time that portals add to their care. Fee for service options must apply for some cases of providers giving lots of care virtually. Patients need to be asked to provide their communication preferences, demographics, share their care teams, and engage in the electronic record. We need to consider policies that reward this updating and engagement as part of healthcare maintenance.