

**Response to Questions for  
the ONC Policy Committee – Meaningful Use Workgroup  
Panel 2: Providers: Working Towards Meaningful Use Stage 3  
by  
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## **Background**

The Regional Extension Assistance Center for HIT (REACH) is a program of Key Health Alliance (KHA) working in collaboration with North Dakota Health Care Review (NDHCR), University of North Dakota School of Medicine and Health Sciences to serve as ONC's Regional Extension Center (REC) for Minnesota and North Dakota. Key Health Alliance (KHA) is a partnership of Stratis Health, National Rural Health Resource Center (The Center), and The College of St. Scholastica (CSS)—all committed to advancing health information technology (HIT), with emphasis on rural and underserved areas.

### **REACH program impact**

The REACH program was created to provide technical assistance to 3,600 priority primary care providers (PPCP) to achieve meaningful use. As of September 2011, the REACH program has signed up 2,867 PPCPs, 80% of its intended goal of 3,600 PPCPs. Additionally, with the critical access hospital (CAH)/rural hospital supplement announced in September 2010, the REACH program plans to provide services to 124 hospitals across Minnesota and North Dakota. As of September 2011, REACH has contracted with over 81 critical access / rural hospitals for services or 65% of eligible hospitals.

### **Contributions to this document**

Material for this document reflects the experience of our REACH field consultants and field coordinators with our clients. Additionally, feedback was received from the HITRC Meaningful Use Community of Practice MU Feedback Workgroup and from staff at the Pennsylvania HIT Extension Center – also called REACH.

## **Working Toward Meaningful Use Stage 3**

### **Experience with Meaningful Use:**

#### ***Do you[r clients'] plan to apply for reimbursement for Meaningful Use of HIT via Medicare or Medicaid?***

Looking at our clients in Minnesota and North Dakota, we estimate that 27% of the hospitals and professionals will be attesting via Medicaid, approximately 43% will be attesting via Medicare and approximately 29% are professionals at rural health clinics which will not be eligible for either Medicare or Medicaid

#### ***When do you[r clients'] plan to begin [their] Meaningful Use reporting period?***

In Minnesota and North Dakota, we see a great deal of variability in this. Despite the fact that our state is advanced in its adoption of EHRs, many have had difficulty in upgrading to

a certified version because of vendor backlogs or have been reluctant to attest in 2011 when stage II would begin so shortly after the final rules were announced. All of our clients eligible for Medicare or Medicaid incentives see attesting to meaningful use as a priority and will begin the reporting as soon as their software is in place and the reports demonstrate that they are meeting the requirements. For those not eligible for the incentives or subject to the penalties, such as the rural health clinics, their timeline is unclear.

***Which objective requirements do you[r clients'] find easy to meet (or exceed)?***

For our ambulatory clients, CPOE, drug-drug and drug-allergy interaction checks, demographics, allergies, vitals (for primary care docs), lab results, patient lists, referral summary (printed copy) and demographics are easy to meet.

For our hospital clients, drug-drug and drug-allergy interaction checks, formulary checks, allergies, vitals, smoking status, decision support, quality reporting, lab results, patient lists, patient education, and for most of our clients, demographics are easy to meet.

Finally, for clients that have been on EHRs for years, reminders and reports on specific conditions have been easy for many professionals to meet.

***Which core objectives have posed the greatest challenges to you[r clients'] meeting the requirements (and why)?***

Clinical Quality Measures (CQM): For both hospitals and professionals, getting the clinical quality measures right has proven to be more difficult than expected. For the most part, reporting measure results is easy however having them accurately reflect the care that is being provided is more difficult. In order to capture activity and exclusion, EHRs are requiring data entry in places different than required on older versions of software. In some instances, there can be duplicate data entry fields in different places in the chart, where one may "count" in the CQM report and the other does not. Getting clarity on which fields to use to assure the reports accurately reflect the patient population has been difficult for some. Redesigning the workflow and training EPs and other staff to use these new fields in order to meet the requirement of a measurement and not to affect care or improve outcomes has proven challenging. With EHRs that have only certified on nine quality measures, finding a relevant measure can be challenging. Specialty providers have even a greater challenge in finding appropriate measures to report. Finally, older versions of software that been upgraded sometimes require manual build of the measures. This turns out to be a time-consuming process.

CPOE has been a challenge for some hospitals. Unless the EHR is configured to allow easy selection of the medication, dose, method and route, entering the order is slow. In some instances, medication ordering modules were imported from pharmacy ordering modules where the pharmacist orders by stock item (2 ccs from a 10mg/cc vial as opposed to 20 mg. This frustrates professionals. When ordering is difficult, it is a challenge to convince professionals to not hand the responsibility of this duty to another "licensed healthcare professional" to meet the measure. Many "pass" this objective because the licensed

professionals are entering the orders on behalf of the providers. This criteria is likely to remain a challenge until the paper chart is completely eliminated from the hospital.

Problem lists are another issue for both professionals and hospitals. Again, ICD-9 codes do not use common terminology for many problems and finding them is time consuming and is dependent on the quality of the search engine. Some vendors sell products that translate more common terminology into ICD-9 codes making this somewhat easier but many of our clients are not using these products because they are an additional expense both in the purchasing and installation of the product. Also, some EHRs do a poor job of distinguishing between acute and chronic problems with an acute problem remaining on a patient's chart until someone removes it. In addition, hospitals have traditionally not identified the "problem" until after the patient is discharged – professionals usually have a working diagnosis (or a "rule-out" Dx) so this requires a change in workflow in order to get the problem in the certified EHR and not just the billing system.

Clinical summaries are a challenge for the professional. For patients new to the EHR, they require redesigning the workflow so that data can be entered efficiently by the staff, but it still requires data entry by the professional during the visit in order to have a complete document available for the patient when they leave. The most challenging is the follow-up plan. Some products do not produce the clinical summary in a patient friendly format, and for our clients who are at federally qualified health care centers (FQHCs), one third of their patients do not read English and many do not read Spanish so the content of a clinical summary will not be understandable. Some clients are not eager to hand them out in the exam room. They are concerned about a potential HIPAA violation because they are finding clinical summaries in the trash outside their offices.

eRx is a challenge for some professionals depending on system performance and their relationship with area pharmacies. We are aware of one clinic in a suburban area whose in-house pharmacy is owned by a large health system and which will not accept electronic transmissions. Since most patients wish to get their meds at that pharmacy as they leave, the clinic believes they will fail this measure since they are only able to eFax.

Finally, health information exchange can be a challenge depending on the other providers in one's community. Some vendors only focus on exchange with clients using the same EHR product and not with other vendors' products. The capability to exchange key clinical information requires an interface which is a costly endeavor for small/rural health care facilities. A bi-directional interface can cost a facility upwards to \$10,000. Many times the EHR will require multiple interfaces, such as lab, or other healthcare entities. In addition, the North Dakota HIE does not have an implemented system such as the Direct Project to allow facilities to meet this requirement. We recognize that one can meet the stage 1 exchange measure without an interface but it is not true exchange.

***Which menu objectives have posed the greatest challenges to you[r clients'] meeting the requirements (and why)?***

Submit immunization info electronically has been a challenge. Providers had expected plug and play solution, but it has turned out not to be the case. One critical access hospital needed to have its files in a different format than was originally planned so it was put on the list to have a new interface built. The vendor was initially going to charge the hospital for this interface but did not. This delay jeopardized the hospital's ability to meet this requirement. Costs have also proven a barrier. Vendor charging additional fees to generate HL7 files that can be sent to an immunization registry, while some state immunization registries unable to accommodate vendor attempts to create interfaces due to staffing and resource shortages.

Syndromic surveillance is not available in many states.

Another is patient education material. When the EHR vendor is bases its meaningful use report on an audit of printing out education material, it misses any material handed out at the EHRs prompting. For FQHCs, translated pieces are almost always from sources other than the EHR.

Another is to provide timely access to records. Many do not want to pay the additional expense at this time to add a portal. They do not trust that certain info will be withheld from patients at the provider's request. Our clients who have been on EHRs for years have chosen to add their portal products six or more months after full implementation, when professionals were more comfortable with the EHR and there was clinical data in the system for the patient to see. For those going live now, adding the portal right away feels too early.

A colleague of mine from the Pennsylvania REC reports that incorporating lab-test results as structured data had been a challenge for some of their clients. For those small independent clinics whose labs are performed at a local hospital, providers are upset that they are being charged to interface with labs and there is a battle related to who should pay for this. Many hospitals are overwhelmed with requests to interface with non-owned providers and there are waiting lists for this to occur. Some hospital labs do not have capability to interface. It is labor intensive to manually enter data and errors are inevitable.

***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?***

Many EHR's do not have certified reports relevant to the provider's patient population while many specialists struggle to find relevant CQMs.

The quality measures mostly align with FQHC Uniform Data System (UDS) measures, except the Bureau of Primary Health Care is planning to require the MU asthma report in 2012 and that report is an optional one not all vendors have written/certified. They do not align well with the required MN Community Measurement measures, particularly the composite measures for diabetes, ischemic vascular disease and asthma care.

***Has the EHR certification program made it easier for you[r clients] to report on the meaningful use quality measures?***

For those who have used them, it is easier to report the requested quality measures. For others, we anticipate the reports will be okay. What is difficult is when the vendor only has three of the optional reports and those available are inappropriate for a specific group of providers, such as pediatricians or midwives when an EHR vendor has opted for the diabetes measures.

Because of the narrow nature of the reports, some of our more seasoned EHR clients have questioned their value. In Minnesota many have designed their workflow in order to comply with MN Community Measurement. Some have been doing quality measures for years, and drill down into much greater detail than what these measures provide. Consequently, the built-in certified reports are less valuable to providers in their present form. These reports require workflow changes, testing, and training to implement properly and some clinics are not willing to do the work required to get these more simplistic reports accurate.

There is also confusion about reporting for MU and reporting for PQRS, the different certifications, whether registry reporting counts if data first flows from the EHR to the registry. PQRS has registry reporting now and also group reporting. We urge moving to a standard set of criteria for both programs and one that is flexible for users to readily create their own reports on measures important to them.

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

We believe that the number one challenge has been vendor issues. This has been supported by my colleagues at other extension centers. "Complete EHRs" are not really complete. Many require additional modules, ad-ons or patches in order to meet meaningful use. In other instances, certified MU versions are not available to clients because of install backlogs. Additionally, in order to get the product to market, MU requirements were forced into existing products and many require unnatural workflow changes. Clients have also been forced to purchase products and interfaces that they will not use. When a complete EHR includes a lab module yet they wish to use another certified lab module, they are forced to purchase the one they will not use since it is part of the "complete" interface. The same applies to syndromic surveillance. Clients are forced to purchase the interface even though a state is not able to receive the information (and it may not be in stage 2).

HIE is a major challenge with some vendors. More focus has been placed on generating an encrypted CCR than on the reception and unencryption of them. Receiving providers may not be able to unencrypt to a human-readable document. Also, statewide HIE is just getting going in many states. This has added hurdles for providers trying to figure out long-term electronic exchange options with other care providers. They don't want to pay a lot of money for a vendor-specific option that only works with clinics using the same vendor. At the same time, sending dummy data via email/SFTP/etc is just a short-term solution.

For safety net clinics the major challenge has been understanding the EHR marketplace and the cost for the software. Also, many of these sites have providers who are very part time and may be using a different system at their main site, so training is an issue.

Another challenge involves material intended to be read by the patient, in terms of language, literacy level and means of distribution. In the vendors' push to create products that are ATCB certifiable, end-user ease-of-use and the creation of patient friendly output has taken a back burner. One of the main drivers of health disparities in the US has to do with health literacy. Visit summaries and patient education pieces that aren't in simple language are not going to address the goals of this effort.

Change management is an issue underlying all of this. Providers are not willing to change the way they work when they don't see the value in it for them or their patients. Many believe they provide good care to their patients using their current processes (either paper or through use of an EHR) and some have the MN Community Measurement data to show for it. Most do not question the value of the EHR, they just question some of the "tasks" they are being required to do to meet the criteria.

***What do you estimate is your [clients'] project cost to implement meaningful use?***

We estimate that it costs our clients anywhere from \$25,000-\$50,000 per professional to implement an EHR in a clinic and that the ongoing costs range between 18 and 22% of that amount.

**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.**

Functionality to support medical home is generally good, but anything that requires additional data entry needs to have demonstrated value. Our experience with patients has largely been that they need a single, best route (staff person) to communicate with, so they may not do well with a list of team members. It's possible that that would be useful internally, but probably only in larger organizations. Being able to record contacts/team members outside the organization could be very helpful (like teacher or school nurse or case worker, etc), but that would not be universally needed in all cases.

Possibly more helpful to support medical home would be a flexible function for creating, storing, updating, printing and sharing care plans. Many providers use the EHR's letter function for this, but that isn't necessarily as updatable or accessible by others.

Also helpful for support of chronic care in general could be functionality to record patient-chosen self-management goals.

Standards for recording family history would be valuable especially if it included the ability to record genetic history. Not mentioned was standards for social history including level of education and some type of "financial health" (as opposed to income). In our goal to reduce health disparities knowing ones financial and educational status can provide us with data to

help to eliminate health disparities. In addition, educational level may allow us to provide educational materials more appropriate to the individual's comprehension

**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 role of a care plan when it comes to specialty care will need to be defined. Will specialists be expected to create their own longitudinal care plan for a patient based on a specific health condition, when in practice they are part of the PCPs longitudinal care plan for that patient? For example, an ophthalmologist treating a diabetic patient with diabetic retinopathy, where the PCP has authorized that referral as part of a care plan that addresses poorly managed diabetes. There will need to be clarity on CMS' expectations for specialists.

Advanced directives are good to support, but not all patients are ready for taking advantage of them. For most of us, readiness is based on age, health, culture, and experience. If the threshold is kept intentionally low, it will encourage use without forcing providers to browbeat patients who are not currently interested.

Communication preference is key information, already collected by most of MN FQHCs due to the difficulties of reaching their highly mobile patient populations.

**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 [clients'] interest in HIEs, registries, or other data integration partners.**

Most providers understand the value of HIE, in fact many assume that when an EHR is implemented they will automatically have HIE capability. They are dismayed to find how complicated and potentially expensive developing that functionality can become.

Developing measures that longitudinally track episodes of care across settings would be extremely valuable as a tool to help fractionated systems come together and organize care to be more effective and efficient. There are many potential barriers to overcome in constructing measures based on data collected across several provider types and care settings especially if it is to be aggregated to create a single pooled measurement –privacy barriers as well as technical ones.

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

In general we do hear some stories about problems patients encountered when this or that clinic adopted an EHR however, most of these stories end with..."it's better now.." Our low-income, immigrant/refugee communities vary widely in reacting to electronic engagement. Some are very savvy and embrace the new functions, some are quite distrustful.

**What objectives in MU Stage 3 would help you[r clients'] achieve the goals of accountable care?**

The objectives themselves seem good. The objectives around better patient engagement and care coordination and drug management will be helpful for successful ACOs to monitor. How they're enforced or implemented by ONC/CMS/ATCBs will have a larger impact than the best intended objectives. There needs to be a more formalized process for ensuring certified products are actually meeting the CMS versions of the measures, not just the testing script from NIST based on the ONC rule about certification. Currently the process relies on professionals and hospitals to test the products in the field and advocate for change when they feel the product doesn't align with the CMS rule. The burden is on them to keep the vendors "honest" beyond certification. Perhaps a part of any CMS audit should include some evaluation of the vendor-supplied workflows/recommendations to catch some blatant departures from either the certification process or the CMS rule. Communication in a large software company may not always be consistent and so the lessons from the certification process may not always be shared with the salespeople, implementation or technical assistance staff. This in-the-field use is a valuable required component for full CCHIT certification and some variation should be considered here.

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

For rural health clinics ineligible for incentives, Meaningful Use has taken a back seat to other, more pressing issues. For others, MU has absorbed a lot of the time and financial resources, which means other priorities have probably been delayed. Others see it as an important project, but where they put it on the continuum of things that need attention, the amount of dedicated time and staff varies. Most are aware that to get the full benefit of the incentive they need to attest in 2012, though some are not aware of the time requirements to achieve real meaningful use.

From my staff person who deals with FQHCs, she states that many Minnesota FQHCs see MU critical to their medical home efforts, but need to postpone development of their medical home model (and certification) until after they have their EHR stabilized. They have new, mandatory MDH reporting; new, mandatory UDS reporting; federal urging to achieve medical home certification; and federal urging to develop HIV programs – they are overwhelmed and don't have resources to staff all these initiatives at the same time. Some embrace the EHR to make the other things possible, some feel the EHR project is a requirement that takes their time away from patients and doesn't make anything better. She is concerned that the short time period between MU stages will not allow providers to shift their attention/resources from a focus on MU to a focus on patient-centered medical home (PCMH) which are a key federal strategy to improve health and cut costs.

## **In closing**

We fully support the use of health information technology to improve the quality, safety and efficiency of the care we provide our patients. We stand behind the intent of the incentive program and the HITECH act and we believe it will be a driving force in transforming America's healthcare. We are concerned however that the tools which will be used to make this a reality are being rushed to market without the close attention to workflow, user needs and patient needs. We do not believe that this program should be decelerated; however, we do believe it should be harmonized with existing programs to provide accountable care, medical homes, and workflows that improve the efficiency of care delivery. Though it does not fall under the purview of this workgroup, we believe that the certification process for EHRs is a critical element in this process.

I would like to thank my staff at the Regional Extension Assistance Center for HIT, the members of the HITRC Meaningful Use Community of Practice Advisory Group, the Meaningful Use Community of Practice Feedback Workgroup, the staff at the Pennsylvania Regional Extension and Assistance Center for HIT and especially Linda Ridlehuber, RN MBA, quality improvement specialist at the Minnesota Association of Community Health Centers and Don Wilson, MD, FACOG, CPE, medical director of Quality Insights of Pennsylvania, for their contributions to this document.

Thank you very much for giving us the opportunity to share our thoughts with you. We wish you luck in formulating your recommendations.