

**HIT Policy Committee
Certification/Adoption Workgroup
Workforce Development Subgroup
Transcript
April 11, 2014**

Presentation

Operator

All lines are bridged with the public.

Michelle Consolazio, MPH – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology

Thank you. Good afternoon everyone, this is Michelle Consolazio with the Office of the National Coordinator. This is a meeting of the Health IT Policy Committee's Certification/Adoption Workgroup, and it's a subgroup underneath Certification and Adoption for Workforce. This is a public call and there will be time for public comment at the end of the call. As a reminder, please state your name before speaking as this meeting is being transcribed and recorded. I'll now take roll. Larry Wolf?

Larry Wolf – Health IT Strategist – Kindred Healthcare

Here.

Michelle Consolazio, MPH – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology

Norma Morganti? Bill Hersh? Don Gull? Elizabeth Royal? Jennifer Pirtle? JoAnn Klinedinst?

JoAnn W. Klinedinst CPHIMS, DES, PMP, FHIMSS – Vice President, Professional Development – Health Information Management and Systems Society

Here.

Michelle Consolazio, MPH – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology

Hi, JoAnn. Joe Heyman?

Joe Heyman, MD – Whittier IPA

Here.

Michelle Consolazio, MPH – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology

Michelle Dougherty?

Michelle L. Dougherty, MA, RHIA, CHP – Director of Research and Development – AHIMA Foundation

Here.

Michelle Consolazio, MPH – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology

Hi, Michelle. Nancy Brooks? Patricia Dombrowski?

Patricia Dombrowski, MA – Director, Life Science Informatics Center – Bellevue College

Here.

Michelle Consolazio, MPH – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology

Hello. Roger Holloway? Samantha Burch? Steve Waldren? And Susan Fenton?

Susan H. Fenton, PhD, MBA, RHIA, FAHIMA – Assistant Dean for Academic Affairs – UTHealth School of Biomedical Informatics

Susan is here, she had to step away and just asked that I let you know she's here.

Michelle Consolazio, MPH – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology

Thank you. And Chitra Mohla for ONC?

Chitra Mohla, MS – Director, Workforce Programs Office of Provider Adoption Support (OPAS) – Office of the National Coordinator for Health Information Technology

Here.

Michelle Consolazio, MPH – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology

Hi, Chitra. And with that, I'll turn it back to you Larry, if you're still available.

Larry Wolf – Health IT Strategist – Kindred Healthcare

Great. Well I want to welcome everybody back. We're continuing our exploration of different environments in which there's health IT and where it would be helpful, perhaps, to have a trained workforce. And we have a variety, a pair of settings today we're going to be hearing from, one rural health, so more I guess geography than a specific setting. And the second is a solo practitioner's office. Joe Heyman has offered up that he would like to give us a view – the view that he lives on an everyday basis as something else to inform us because it's very easy to think only about the large providers that have training departments and all kinds of staff to help the organization, and that's not always the case. In fact, if we look at number of physician practices, most of them a really small. So, it's actually more typical to be, in terms of practice numbers, to be having folks like Joe than the large organizations.

So with that as an intro, I guess I'll hand this over to Roger. And Roger, would you give us a couple of comments about yourself by way of getting started?

Roger Holloway, RN, MHA – Executive Director, Rural Health Resource Services – Northern Illinois University

Yeah, I'd be happy to, Larry. Yes, my – Roger Holloway here and my perspective on this issue is that I've – my career has really been a fair amount on the clinical side as a medic and a radiology tech and a Registered Nurse. And then after going back to school, returned to do hospital turnarounds, particularly rural hospitals. And so this perspective we'll be talking about today really is a combination. There were about four Regional Extension Centers that through the Rural CoP began to look at some of the issues that surround rural organizations that may preclude them from getting to Meaningful Use.

And this is a somewhat broader perspective, because it really takes into consideration, the kind of gamut of issues they run into. But my takeaway, and the reason that I put these pieces together is that much of this responsibility for making these things occur lies with the IT staff that's available in these rural hospitals, who frequently have evolved from some other opportunity, tend not to be health informaticists or people with extensive background. And yet we will rely on these individuals to make decisions that can have a profound effect on the organization and its success. Not only on the Meaningful Use side, but just in terms of the transition that we're going through in health information technology and still playing an important role in their community, but yet able to survive in a state and national level as well.

I currently serve as a Director, Co-Director for the Regional Extension Center in Illinois. I also am President of the Illinois Rural Health Network, a high-speed broadband FCC project intended to connect rural healthcare facilities on a high-speed fiber network, which we have accomplished over the past five years. So, Chitra, who will be doing the slides?

Chitra Mohla, MS – Director, Workforce Programs Office of Provider Adoption Support (OPAS) – Office of the National Coordinator for Health Information Technology

The operator will forward the slides.

Roger Holloway, RN, MHA – Executive Director, Rural Health Resource Services – Northern Illinois University

Okay, very good.

Chitra Mohla, MS – Director, Workforce Programs Office of Provider Adoption Support (OPAS) – Office of the National Coordinator for Health Information Technology

Let them know, next slide.

Michelle Consolazio, MPH – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology

You could just say next slide, and that would be great.

Roger Holloway, RN, MHA – Executive Director Rural Health Resource Services – Northern Illinois University

Okay. And I think the rationale behind the title was I always believe there's a foundation that has to be laid in any kind of enterprise so you can attain that goal. And so the challenges on health information technology for rural providers, for rural organizations, whether they're public health or they're long-term care or they're acute care or it's a two physician practice; those are really critical elements in terms of building the capability and knowledge base necessary to be successful. Next slide, please.

There are typically three scenarios when we think about acute care facilities. There are the free standing that are owned or maybe affiliated, but it's a variety of relationships with a larger organization. Then there are the ones that are owned and operated both by for-profits as well as not-for-profits. In Illinois, we're seeing a lot of activity with acquisition of some of these facilities where it relates to market share or some other competitive territory between two larger institutions. So, we're seeing fewer and fewer standalone facilities and as we go look at these issues, they really fall hard on standalone facilities, because of infrastructure, because of training education, etcetera. Next slide, please.

These are some of the top needs that we as a group put together that the replacement of not only software but hardware in these organizations. And in getting back to server room upgrades more space, these are organizations that may have not followed a larger trend to moving away from servers and moving into a cloud setting for their services. The security risk analysis is, as an REC, that's one of the things we've been very active in because when we do an assessment, in about 80% of those settings that we work in, we find issues that require some level of intervention to be able to minimize any audit or penetration of data. And again, many times that wasn't – when the vendor sold them the EHR it was, you'll be able to reach Meaningful Use and this is everything you need, and it's turned on so you're good to go. Unfortunately, as we're finding out now that there are certainly other issues and generally relate to infrastructure or knowledge or awareness about those issues even being an issue. Next slide, please.

To move – for the better Internet access, the bandwidth, one of the things that we commented on early was, you can deploy the greatest EHR but if you can't get the information out of the building. And many of these organizations, actually the majority of organizations that we were connecting with, were attempting to operate on a T1 line by itself, sometimes – routinely with no backup. But yet here we are anticipating moving to a nearly electrified picture for everything they do, images, information, sharing of the transfer of information.

On the personnel side, many times you will find in a – you'll, if they're fortunate, they've got an FTE or they've got part of an FTE, and it's maybe someone who used to work in maintenance and kind of liked computers and so they moved them to that area and retitled them. And these are people who are always busy keeping whatever system they have up and running and it really is a what's on fire approach that you see more often than a strategic plan, an IT strategic plan that's implemented and approved by the board and resourced.

I did a kind of a back of the napkin survey with about 25 rural critical access hospitals and what we found was that there were two hospitals out of that group that actually had an IT strategic plan and that there was funding preserved to actually being able to enact it. Working right now with a critical access hospital, one of the top 100s in the nation, building a new hospital their IT person works two days a week. And when you look at the challenge of rema – managing remote facilities and educating the folks on the other end, both the clinical staff, business office staff, etcetera, it's a huge job.

On the hardware side, again additional or upgraded servers and certainly we see a lot more movement to the server host. And one of the reasons we've always encouraged people to do that, because there just isn't an adequate supply of well-trained folks in rural settings to be able to meet the need and maintain that. And it gets even worse for provider's offices. Because they're going to have to buy some part of a service to be able to ensure that their system isn't brought to its knees and no one can help them so they're unable not only enter any data into the record, but they're also unable to bill on behalf of any services they are providing. The router wireless upgrades those – for our network, when we developed it here; we initially thought we were going to have a lot of wireless to get to places. We're fortunate and developed that with a lot of fiber because the wireless connections for these facilities are extremely expensive and have a relatively short shelf life in terms of the need to replace them. Next slide, please.

And these are just some of the pieces that are out there, the patient portal. The system upgrades, we have one of the biggest issues we see out there right now is the availability of 2014 certified. And so you go to that person who may be half of an FTE or an FTE and they have two remote office locations, in addition to the hospital to upgrade, educate the existing staff and ensure that they're all able to meet those requirements. It is a huge, huge challenge. Submission of public health data that has gotten better because of the increasing presence of public health nodes that we're seeing. And really being able to share not only the HL7 data, but lots of improved technology around sharing of images.

The challenge you have is being able to have that conversation at the local level, in a way that the person who's on the receiving end is able to understand the value or importance of that, because all of these come with some level of expense to do it. And so it's really moving towards the idea of how do you develop a system, from a foundational perspective, that's going to meet the needs of that organization whether it's a public health department, mental health, long-term care, small group practice or acute care hospital. And not just meet them today, but so they are not redoing something two years out that with other information they might have made other decisions. Next slide, please.

And this just goes – on the clinical side, much of the equipment, as they're moving, not just even the telemetry and nurse call systems, but all of these pieces, that responsibility and insight is going to have to flow from that person within the organization who has that responsibility in the IT area. You certainly don't want to be in the position of relying 100% on what the vendor is telling you you need to have or how it's actually going to work. If there's not that level of technical understanding or objectivity, many people have and organizations have spent dollars that they could not afford to re-spend, but at some point in time, had to do it because there wasn't an alternative for the solution they were attempting to provide. Next slide, please.

And again, all of this requires that coordination between these various systems, because as we look at eHealth monitoring, as we look at tele-ICUs, tele-psych and remote locations for many of these smaller organizations. Because they also tend to employ the majority of their medical staff on the primary care side, but yet they interact with groups of radiologists, groups of specialists and they have to be able to exchange information, work through the interface issues. They will have between a variety of software vendors around electronic health records, PACS systems and laboratory equipment, etcetera.

So it really is – it's no longer that narrow area of are the monitors working and is our system up, it's taking that step back and saying, what is the plan, how will we accomplish it, what kind of resources will it take. And a lot of that expectation for direction falls to the people who are in the IT shop, because many times it's not the CEO or CMO or CFO that has that knowledge and background. It is that health information technology person who is going to be relied on and they're making, absent a building project, these are some of the most capital-intensive decisions they will make. Next slide, please.

And we're dealing with many times older facilities, lots of renovation opportunities. And again, thinking about the workflow redesign that occurs typically in electronic health records, having that insight to be able to coordinate those pieces. So, when an area is changed that the appropriate type of infrastructure relative to health information gets to where it needs to be so they can do remote monitoring, if necessary. Or telemetry or many of those other things that are all things that need to occur in a rural setting so they can maintain the patients that they're providing service for, and they don't all end up being sent out to some other larger facility that's 20 miles away. Next slide, please.

The personnel training, again as I said, many of these organizations, they are usually the first or second largest employer in the community. They tend to employ nearly all of the primary care providers in there – in that area, all of whom are within 10 or 15 miles for the most part. And they need to be able to share that information between the ambulatory office, the acute care organization and, in most cases or in all cases, some type of statewide health information exchange. And someone has to think that through, think about the systemness of it and be able to make the decisions and recommendations around the technology and the support necessary. And again, 40% of these organizations today have a negative margin, so the idea of going out and hiring a health informaticist for a small hospital, just – are not only if you could find them is one thing, but the other part is, they're looking at ways to stay in business rather than to spend any additional funds. Next slide, please.

Oh, excuse me. In the – I guess the sum of that is, when you look at that rapidly changing HIT environment and at the internal intelligence that will guide these extremely necessary, but costly decisions, is that person who may or may not have a knowledge base in order to assist with those decisions. But in cases, even absent that knowledge base, they will make decisions. Questions?

Michelle L. Dougherty, MA, RHIA, CHP – Director of Research and Development – AHIMA Foundation

This is Michelle –

Larry Wolf – Health IT Strategist – Kindred Healthcare

So Roger, its Larry Wolf.

Roger Holloway, RN, MHA – Executive Director, Rural Health Resource Services – Northern Illinois University

Yes.

Larry Wolf – Health IT Strategist – Kindred Healthcare

So I guess I'm hearing about the – so the level of difficulty that these settings are having. Have you found that the REC has been helpful and effective in helping them bridge the gap of they don't really have experienced IT staff? That as you said, they're repurposing people who maybe know a little piece here about they've been helping with monitors, monitor tech kind of things or they were building maintenance but had comfort with running wiring or whatever it is, but not really –

Roger Holloway, RN, MHA – Executive Director Rural Health Resource Services – Northern Illinois University

Not really that big picture piece.

Larry Wolf – Health IT Strategist – Kindred Healthcare

Not a big picture piece and not a broad base of experience, right. So is that something the REC has been able to – successful with or do you feel like you're –

Roger Holloway, RN, MHA – Executive Director Rural Health Resource Services – Northern Illinois University

I would say not as successful as I feel it needs to be. We've certainly made some headway and we've done it, I think, in a couple of ways. One, I was so fortunate early on to connect up with Norma and exported a lot of the availability of that. We also, in conjunction, worked with USDA around some of the funding they were doing for IT systems, and suggested that they – that a boilerplate IT strategic plan would be a requirement of receiving funding on those sites. Because nothing worse than someone borrowing money and buying the thing that's really not their solution.

Larry Wolf – Health IT Strategist – Kindred Healthcare

Um hmm.

Roger Holloway, RN, MHA – Executive Director, Rural Health Resource Services – Northern Illinois University

And I think the other thing is we've also been very involved with the health information exchange side, which we've conveyed to the small and rural constituency at a state level. But also, it's been one of the discussions that has repeatedly been in place at the rural CoP from – at the ONC level. So I think there's a growing awareness that it's not just about, oh yeah, I've got a certified EHR and so we're good to go. It's those other elements about if my future holds that the majority of our visits with a cardiologist or pulmonologist will be done in a telehealth world, what kind of infrastructure do I need to support and facilitate that.

And the same with, whether its radiology or whether its e-monitoring at home, this is a brave new world for rurals to think about because their healthcare model is very traditional in that kind of red brick building perspective. So I think we've made some headway, have we made – do I feel that 80% of the rural settings are in good shape or moving that way, no I don't.

Larry Wolf – Health IT Strategist – Kindred Healthcare

So, is there a sustainable model for the REC in Illinois or is that about to hit a cliff?

Roger Holloway, RN, MHA – Executive Director, Rural Health Resource Services – Northern Illinois University

Yeah, I mean we're – we've done a variety of things I guess. One is we've entered into other REC-like agreements to provide Meaningful Use services to high volume Medicaid providers in the state who either weren't engaged or haven't moved from AIU. We've also taken some additional slots from another REC that – where they were not meeting those metrics.

Larry Wolf – Health IT Strategist – Kindred Healthcare

Um hmm.

Roger Holloway, RN, MHA – Executive Director, Rural Health Resource Services – Northern Illinois University

And the other thing is we've developed four service lines around privacy and security and remediation, Stage 1, year 2 Meaningful Use, Stage 2 Meaningful Use and workflow redesign.

Larry Wolf – Health IT Strategist – Kindred Healthcare

And so you're getting some uptake on customers for that as part of your sustainability?

Roger Holloway, RN, MHA – Executive Director, Rural Health Resource Services – Northern Illinois University

Right and we're really seeing a fair number of folks who did the 90-days in one year and then they, for whatever reason, may have gotten a little bit lax and really – so we're putting together a monitoring service where we'll extract the data, look at it and then tell them where they are or are not. And one of the other things we're doing in conjunction is that on our high-speed broadband site, the Illinois Rural HealthNet. We're looking at having a data repository in conjunction with the statewide health information exchange, to be able to facilitate the exchange of data between small organizations and the state at a monthly cost to be able to sustain that system.

Larry Wolf – Health IT Strategist – Kindred Healthcare

So sort of a bridge from the local –

Roger Holloway, RN, MHA – Executive Director, Rural Health Resource Services – Northern Illinois University

Right, right.

Larry Wolf – Health IT Strategist – Kindred Healthcare

– into the state HIE.

Roger Holloway, RN, MHA – Executive Director, Rural Health Resource Services – Northern Illinois University

We're connecting to the organizations and with the new Health Connect fund, we can then also now get to the provider side with bandwidths that are 10-20 times greater than what many of them had available before and are the – they're actually usually lower cost than what they were paying.

Larry Wolf – Health IT Strategist – Kindred Healthcare

So I'm hearing a big piece of the value you bring to these folks is helping them with getting enough bandwidth to actually run Internet-based applications.

Roger Holloway, RN, MHA – Executive Director Rural Health Resource Services – Northern Illinois University

And I think not only that piece of it, but being able to discuss and develop a pretty concise picture of how these foundational pieces are critical to them today. But how the appropriate selection and choices down the road really become tremendously beneficial.

Larry Wolf – Health IT Strategist – Kindred Healthcare

Great. Anyone else on the workgroup have questions or comments for Roger?

Michelle L. Dougherty, MA, RHIA, CHP – Director of Research and Development – AHIMA Foundation

This is Michelle, I had a question.

Roger Holloway, RN, MHA – Executive Director Rural Health Resource Services – Northern Illinois University

Sure, thank you.

Michelle L. Dougherty, MA, RHIA, CHP – Director of Research and Development – AHIMA Foundation

You mentioned that the IT staffs often were responsible for implementing these projects they had large project budgets. Can you talk about what collaboration they have with other business areas, clinical departments or non-clinical departments in both deciding and/or implementing the technology acquisitions that they have?

Roger Holloway, RN, MHA – Executive Director Rural Health Resource Services – Northern Illinois University

Well, I think they always – they're always getting input from the pharmacy side or the nursing side or the DME side. I think the challenge is that if my perspective is pharmacy or nursing time and attendance, I have what I like and there's not that – the challenge they have is having that discussion about the greater good model for coordination of these various aspects. And saying, there's no perfect for everyone, there's a that's really great, but it's not – or really good, it's not perfect.

So I think that they certainly do get input, but they also need to have that knowledge base that they're able to take two steps back and say, we can do these things. But if we do that, we're going to have an – issue – we're not going to be able to share information in a way that we'll be required to for quality metrics or our reporting to public health. So I think it takes that not just technical perspective, but the knowledge and awareness of how do you put these pieces together. And it may not be perfect, but it will continue to enhance the organization and yet meet all the requirements that are being placed on these organizations.

Michelle L. Dougherty, MA, RHIA, CHP – Director of Research and Development – AHIMA Foundation

And that makes sense. Thank you. And then my second question was around whether you have seen any innovative incumbent training methods, tools, resources; anything that has had some uptake or benefit in this area. I think we've heard in the past some of the challenges with the time to do training during the day or the inability to maybe do formal education to advance their careers. Wondering if you in your exposure to so many different real providers may have witnessed some kind of nuggets of workforce training or development that could be leveraged.

Roger Holloway, RN, MHA – Executive Director Rural Health Resource Services – Northern Illinois University

Yeah, actually, one of the things we did probably in our first year on the REC, we developed a whole series of educational webinars that were provided free to physician offices. And then we even, in conjunction with University of Illinois at Chicago, developed a curriculum, a certificate oriented curriculum for – that was only provider based. Because what we were wanting to do was create a cadre of physicians who were so knowledgeable on the bigger picture and the way to maximize the value of electronic health records in their provision of primary care services, that they would be dangerous with their knowledge.

Unfortunately, what we didn't get was a lot of physicians who were willing to sign up. And it was – we priced it at a very de minimis cost, but – so; I think the webinars worked great. We didn't see the physician attendance that we wanted to in the webinars, but we saw a lot of the practice managers and office staff, who were walking through the requirements of, when we say health information exchange, what does that mean? What are the things you should consider as you're selecting an EHR? What do you expect it to do and what are the requirements that it has to meet?

So I think the webinars worked well, so we've continued to use those, but we've also learned to really target the content and then identify in a variety of kind of synthesizing ways, who it's actually valuable to and who it would be of interest to? So, I think that's worked as well because trying the email blasts and things like that just never got the work. But when we talked about how do you access the public health patient portal so you can meet the Meaningful Use requirements, we – the attendance for those was very good. It was not uncommon to have 60 or 80 people on those live webinars.

Michelle L. Dougherty, MA, RHIA, CHP – Director of Research and Development – AHIMA Foundation

Thank you.

Norma Morganti – Executive Director, Health Information Technology Learning Resource Expansion Grant – Cuyahoga Community College

Larry, this is Norma, I have one – thank you Roger for the presentation. And I guess my question for you would be; are there a couple of topics that you would recommend that are really necessary in this space for consideration? I mean, based upon where you know the folks are right now, what are some recommendations just around workforce?

Roger Holloway, RN, MHA – Executive Director Rural Health Resource Services – Northern Illinois University

Well I think one of the things we've seen over and over, particularly where we've already had someone meet Meaningful Use, they can – they get the 90-days. But if they don't – if they only look at it as a software implementation, they don't begin to reap the value of it that they're going to want for participation in the ACOs and Medicaid medical home models or in some of the PQRS pieces. So I think education and training to a provider's office to say, you've bought a very expensive piece of technology, here's the way to make it valuable to you, as a primary care provider in that type of setting. And I think the same theory would also come into play in public health, as we see more and more primary care that's being offered in a variety of settings outside of a traditional physician's office.

Norma Morganti – Executive Director, Health Information Technology Learning Resource Expansion Grant – Cuyahoga Community College

Thank you, Roger.

Roger Holloway, RN, MHA – Executive Director Rural Health Resource Services – Northern Illinois University

Sure. Well thank you all for the opportunity to have this discussion.

Larry Wolf – Health IT Strategist – Kindred Healthcare

Well thank you for bringing this to us, we appreciate the time and the work you're doing to keep things working in the rural areas. So let's move on to Dr. Heyman.

Joe Heyman, MD – Whittier IPA

Well hi, everybody. I'm Joe Heyman, I'm an OB-GYN. I've been in practice for 41 years, since 1973 until 2 weeks ago when I finally closed my clinical practice. I'm a former President of the Massachusetts's Medical Society and a former Chairman of the Board of the American Medical Association. And in 1984, I founded an independent practice association, which is a not-for-profit group of 250 physicians in a relatively rural area in the northeastern part of Massachusetts, called the Merrimack Valley.

And I just want to say a couple of things. One is, all of the barriers that Roger just described, when you're in a small practice, they're there in spades. And I also wanted to say that you're going to be seeing some actual physician quotes, and I've gotten permission from each of those physicians. There are also two physician notes you'll see, and both of those physicians have given me permission. And there's actually one patient's records that you're going to see, and she happens to be my mother-in-law, and she has given written permission for me to use that. So with that, we'll go to the next slide.

So what you see here is, at the American Medical Association, we have a group of delegates who are in private practice and during the year, between meetings, we have a Listserv where we all interact about what we can do to try to preserve private practice for the physicians and patients who prefer those, that opportunity. And I suggested to folks that, this was only a week ago, but I suggested to people that I'd like to have some constructive suggestions about workforce and some suggestions about what their realities are when it comes to health information technology.

And of course, the first thing that happened was, I got this email back, which of course is not a constructive thing about workforce, but it does represent the feelings of a lot of physicians, a lot of physicians. And the general tenor of it is hey, we're here to take care of patients, we're not here for the purposes of record keeping, especially for third parties who want information from us; that isn't our job. And I'm not going to read the entire thing to you, but I think it makes that point very well.

So, I wanted to tell you about a study that occurred, next slide. The AMA, about every decade, does a study on physician professional satisfaction and in 2012, they started a new study using the RAND folks for actually doing the study, but it was sponsored by the American Medical Association and it involved 30 physician practices in 6 states. The interesting thing about it was there weren't a whole lot of questions about IT. And when they started going out to the practices, after 6 practices, they realized that they had to go back to the table and redesign the study, because every single one of those practices put health IT at the top of the list of things that affect physician satisfaction. Next slide.

So the interesting thing, and something that most everybody knows is that in concept, physicians love the idea of having an electronic medical record and those of us who have them, and I personally have had one since 2000, so that's 14 years. Only 20% of them would probably go back to using a paper chart. We recognize that there's better ability to remotely access patient information from our homes and when we're in a hospital, if we want to look at a patient's chart in our office, it's very easy to do so. There are several ways in which they improve quality of care, and those ways are pretty obvious. I would not include Meaningful Use as one of those, but of course, that's my bias. The truth of the matter though is that we always talk about evidence-based care and so far, there hasn't been any evidence that Meaningful Use actually improves quality. The potential of EHRs to increase professional satisfaction in the future definitely is there and most people are interested in health information exchange. Next slide.

However, on the dissatisfaction side, this is what came out in that study. First of all, usability has become and increasing problem. The more that these EMRs try to achieve the ability to collect and manage information for third parties, the less likely they are to be easily usable. So we all recognize that ACOs need all kinds of analytics, we recognize that the government wants to measure quality. We recognize all those things but those are all issues that are not what an EMR was originally created for. And it's my own personal feeling that there ought to be third-party apps for those things that don't interfere in the workflow of a physician. Physician's complained about the amount of time that it takes them to type in things. The fact that they don't look at the patient anymore, the fact that the work itself is less fulfilling because it's inefficient and a major, major criticism has been the inability to exchange health information.

Also, when people get other people's electronic medical record reports, either by fax or in an email, they get this 3 or 4 page document with a huge review of systems, with all negatives in it and it's hard to find what's really important in that record. There are incredible problems with the pricing of this technology and as we ask for additional things, like interfaces, for example, we get nicked and dinged on every single thing that we need to add to make these things more valuable.

And as you can see at the bottom, the – apparently, these are more prominent among senior physicians, although I'm a very senior physician and I love my EMR and I used it for the last 14 years. But for some reason, I think those of us who were used to a much more hands-on relationship with the patient, rather than this team stuff, feel that this is something that separates us from our patients. Next slide.

So the study shows also that there have been practices that have taken action to improve their satisfaction, allowing multiple modes of data entry, having somebody follow you. If you're in an area where you can help medical students, sometimes you'll have the medical student actually enter the information while you just deal directly with the patient. Or you may do dictation and then have somebody else transcribe it later, into the electronic medical record. Generally, people who have those abilities are happier with EMRs than those that don't.

They came up with a term called a flow-manager, which apparently is somebody who's sort of a triage person. Or a person who guides patients so that the physician can just say to that person, look, I need these four lab tests, you go ahead and order those four lab tests and take care of the patient from there on in. And the physician can then go to the next thing, whereas if they're doing it themselves in the EMR, it'll take them 5 or 10 minutes to just order the four things that they need to order. Because they have to find the appropriate diagnosis for each of those things in order to be able to enter them, and it becomes more of a burden. Next slide.

So I just thought I'd show you three comments that were on that Listserv that I thought were very illustrative of what I'm talking about. But in addition to that, if you have the time to go to the actual RAND Study, it is filled with really interesting and constructive ideas about how people are trying to cope with this technology. As you can see, the worst thing in this particular person's opinion is the fact that they won't talk to each other. And she feels that unless there's a law that makes them talk to each other, they're never going to really talk to each other.

And then the second problem is what I would call the perfect storm of changing from the 4010 platform to the 5010 platform, the Meaningful Use requirements, the difficulties with the sustainable growth rate formula and then moving from ICD-9 to ICD-10. All of these things happening at the same time do not make for a lot of physician satisfaction. And she points out something that I feel very strongly about and that is, that because of this need to constantly meet requirements from third parties, the EMR vendors do not have the time or the energy or the resources to actually improve their EMRs, they're busy trying to meet all these demands. And each one of these demands increases the cost of the technology. Next slide.

Barbara Hummel points out that, and this is a very common problem as Roger said, she had a previous system that she was very happy with, however she has Windows XP, so there are two problems. One is that she needs to move to the more advanced Windows, but the other is that her EMR company was purchased by another bigger company, which had another EMR, which was much more expensive. And they stopped supporting the cheaper EMR that she had, and then turned around to her and told her she needed to buy the more expensive one. And when you're in solo practice, just like those little hospitals, you have to worry about every increase in overhead cost. She also points out that in her area, there are three hospitals, and all of them using EPIC and none of the three versions of EPIC can talk to each other, let alone talk to the physicians in the community. Next slide.

And this is me and as I said, I've been very happy. I never would have been able to afford this without my EMR. I don't have to pull charts; I didn't need space for filing. I only needed one additional person in my office and frankly, it was sort of a concierge practice without the subscription fees. And as I said before, that EMR has become less usable with lots of extra clicks interfering with my workflow since the introduction of the Meaningful Use requirements. Next slide.

So this is something I'm very proud of. Our IPA, which is 250 physicians, decided that we would actually invest in having a health information exchange in our community. What you're looking at is actually a screen shot of the genuinely live, really working health information exchange. And what you'll see at the top, along the top, is each of the times that a patient encounters somebody in the healthcare system; whether it be a physician, a pharmacy, and a laboratory, whatever. And those little circles that you see are the progress notes or the discharge summaries or the operative note. The bars that you see are the problems, when they start and how long they last until they are resolved. And below, what you can't see would be vital signs and medications, allergies are displayed as well, right under the patient's name, but Alice doesn't have any allergies. And you can graph the laboratory information and the vital signs.

So if you were to click on one of those little circles – next slide. You would actually open up a progress note from a particular physician, in this case it's an ENT doc, and you'd be able to scroll down and see the rest of that progress note. Next slide. And if you clicked on another circle, you would see a different progress note from a different physician; in this case it's a podiatrist. And that person's progress note. Next slide.

So the advantages of a physician-owned health information exchange, which probably nobody's ever heard of because there are very few in this country are that at least in our area, patients are in more than one contracting network. We have Lahey, BI Deaconess, Tufts, Partners and Steward Healthcare networks, and we never see a patient who is only in a single network. And the only way for us to actually have complete clinical information on any patient, is by having a regional HIE that cuts across all those contracting situations. The other advantage for patients is they don't need six different portals because they have two hospitals and four physicians, they can all go to one portal to see what they need to see. And what's most invaluable to us physicians is we don't have to accept imprisonment in exchange for getting some sort of technology that's given to us by a hospital or a contracting system. Because it's very difficult to give those things up when you leave. Next slide.

So I then asked myself, what does this have to do with this workforce thing. And I tried to answer that question. So one thing is that as Roger emphasized, I think, if you're in a large healthcare system, you can much more easily afford all of the things that you need for an IT infrastructure, but you still can't get all the clinical information. And small practice physicians and their patients prefer a different setting where they feel more like individuals and less like a number. And they prefer a situation where they actually can see a single physician, and there are actually single physicians who actually go and see their own patients in the hospital still in my community. Next slide.

So small practices definitely present workforce challenges and you can look at them as challenges or you can look at them as opportunities for somebody very smart to come up with an innovative idea. And I think our HIE vendor, for example, has done so because what that vendor has done for us is, they scaled it down so that we can afford a health information exchange that's actually sustainable for at least the next five years, even if a hospital didn't join it. And on the other hand, as a hospital joins, then the price goes up. So instead of asking for all the money up front, they've done a scaling that allows them to come to a customer like us. Whereas there is no, or at least it's very uncommon as far as I can tell, to find an HIE vendor that can actually come to somebody as small as we are and provide them with that sort of service. So – next slide.

So we need innovations that can be directed at small practice physician organizations. If you take a physician organization and treat it as if it were a large practice, even though the members are financially independent, you can probably provide a lot of the services that physicians need at a lower cost. Our IPA has been subsidizing, for example, the hardware support and the initial phone call for somebody who's having a problem and they don't know whether it's software or hardware. We've lowered that price for physicians to \$1000 a year per physician. This year we decided to stop subsidizing and my bill as an individual physician went up to \$4000. So if I'd been in a practice with five physicians, that bill would have been \$20,000 a year. There are about 500 IPAs with 120,000 primary care physicians and 144,000 specialists across this country. And they are an untapped resource for an opportunity to provide services that people are not providing now. Next slide.

So these are the kinds of things that I think we need help for small practices with. First of all we definitely need some better EMRs that talk to each other. People need help with Meaningful Use, and I recognize that the RECs are supposed to do that. But it's a lot easier when you have a single individual within a physician organization who actually is out every day in physician's offices in the same community so that everybody knows her and knows who to call, to give that support for Meaningful Use. We need that IT support; we need help with workflow design, transcription, scribes, and those flow managers that I discussed earlier, interoperability.

And I think we need applications that I don't believe that 10 years from now or maybe 15 years from now, people will be using electronic medical records, unless the government absolutely proscribes that in order for you to get your pay, you've got to use them. But it would be much more innovative if we would allow people to just develop new applications that maybe sit on top of a health information exchange or just work on a cell phone or something like that, rather than commit everybody to EMRs forever. Next slide.

So, this is just my contact information. And I would just say, I do have a copy of the RAND Study and if anybody's interested in it, you can just email me and I'd be happy to share that with you. And with that, I'll just open it up. Is anybody still there?

Larry Wolf – Health IT Strategist – Kindred Healthcare

Hello, Joe, I'm off mute.

W

This is –

Michelle Consolazio, MPH – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology

You're off mute Larry.

Larry Wolf – Health IT Strategist – Kindred Healthcare

I'm sorry, yeah, I flipped myself to mute on when I was checking, seeing if it was mute off. So Joe, thank you for that. A lot of both anecdotes and through RAND, a much more extensive, in-depth study as well. And I'm wondering in terms of the workforce connection piece that you addressed at the end, it sounded like you're talking about services that traditionally are provided through consultants of various kinds, is that the kind of model you're thinking might work or are you thinking something different than that?

Joe Heyman, MD – Whittier IPA

Well, I guess I'm thinking on two levels. One level is if you consider an IT vendor a consultant, I don't know, but I mean, it seems to me that most of the major IT vendors aim their products at larger organizations. There are a few EMR companies that started out aiming them at smaller organizations, but even they have products now that, first of all, they get bought off by larger organizations that tend to –

Larry Wolf – Health IT Strategist – Kindred Healthcare

Sure.

Joe Heyman, MD – Whittier IPA

– move toward larger organizations. And my argument is, there's still a huge – we don't even know if ACOs are going to work –

Larry Wolf – Health IT Strategist – Kindred Healthcare

Um hmm.

Joe Heyman, MD – Whittier IPA

– and yet – I mean, I know everybody across the country is doing them, but when we had HMOs in the beginning, everybody across the country did them, too, and then there was this incredible pushback and they didn't work very well. So, we don't even know whether 10 years from now anybody will be in an ACO and it just seems to me that we could be addressing smaller practices by going to their organizations instead of just aiming at the smaller practices, by scaling down so that things are affordable for smaller practices. So sure consulting might be important, like a REC, but on the other hand, you could have a person who, or maybe a company, that provides some of those services in a more inexpensive way by allowing the physicians to pool their need. And maybe they work 3 days a week in one place and 2 days a week in another or a half a day in place and half a day in another, that's what I was thinking about. And maybe it's just a pipe dream, but –

Larry Wolf – Health IT Strategist – Kindred Healthcare

No, so I guess what I'm hearing you say is, two things. One is that there's a market dynamic that even vendors who start off addressing the needs of a small practice, either if you will grow upstream, there's probably more revenue opportunity with bigger practices or they get bought by people who are upstream.

Joe Heyman, MD – Whittier IPA

Right.

Larry Wolf – Health IT Strategist – Kindred Healthcare

And then as in the example of the doc whose system is no longer available, all of their current customers are faced with the lack of – not only lack of support, but in the case of, if you've been on an old hardware or operating system platform. You literally have no choice but to do something, because either the hardware stops working or the software stops working and you've got to do something.

Joe Heyman, MD – Whittier IPA

Right.

Larry Wolf – Health IT Strategist – Kindred Healthcare

And so it forces you into an upgrade when in many ways, the old thing was working just fine.

Joe Heyman, MD – Whittier IPA

Exactly. Another thing that I think that happens in that situation is, many of us, especially in smaller practices, decide that it makes a lot more sense to avoid that problem in the future by using a cloud-based service instead of having a server in our offices.

Larry Wolf – Health IT Strategist – Kindred Healthcare

Sure.

Joe Heyman, MD – Whittier IPA

And what happens then is that when you want to have a health information exchange and you have to have an interface between that cloud-based server and your health information exchange –

Larry Wolf – Health IT Strategist – Kindred Healthcare

Right.

Joe Heyman, MD – Whittier IPA

– the price for making that interface is higher than it would be if you just had the server in your office.

Larry Wolf – Health IT Strategist – Kindred Healthcare

Interesting, so again, sort of the bind of, even if you're going for what might start off as a low cost solution, as you add in the things you need to make it functional –

Joe Heyman, MD – Whittier IPA

Right.

Larry Wolf – Health IT Strategist – Kindred Healthcare

– it winds up becoming a lot more expensive.

Joe Heyman, MD – Whittier IPA

Or it can, I mean, I'm not an expert on that because I never had a cloud-based system. But I am becoming an expert on how much it costs to interface a cloud-based system into our HIE. So, as opposed to folks who have it in their office and we just extract it from them.

Larry Wolf – Health IT Strategist – Kindred Healthcare

Right. Well, partly you're giving up management control; someone else is running the system.

Joe Heyman, MD – Whittier IPA

Right, right.

Larry Wolf – Health IT Strategist – Kindred Healthcare

The scale of what they're doing may exclude some of the more simple approaches you could use if it was a freestanding server.

Joe Heyman, MD – Whittier IPA

Right.

Larry Wolf – Health IT Strategist – Kindred Healthcare

So, I like – I'm sort of intrigued by your notion that either there are groups that physicians already have, like IPAs that give them a way to administratively work together, even while they maintain separate practices. Or other ways to sort of do some kind of small-scale group purchasing.

Joe Heyman, MD – Whittier IPA

Exactly.

Larry Wolf – Health IT Strategist – Kindred Healthcare

And then the workforce support issues, on the IT side, would come – would actually scale up because now a bigger organization is providing the resource or doing the purchasing.

Joe Heyman, MD – Whittier IPA

Right. I mean I can tell you this – when I first started my system, I went to the hospital's IT guy, and the hospital's IT guy was exactly what Roger described. He was a guy who was kind of a nerd, who was running my small hospital's 140 beds, their IT department. And he was the only IT person in the hospital and he set up my network. And a year and a half into it, I was installing a program with my EMR open at the time and to make a long story short, I corrupted my database and I lost everything, everything. I thought I was going to lose my license and it was just after I was elected to the AMA Board and I could just see the headlines, AMA Board member loses 2500 patient charts. And it was just an absolute nightmare for three months, until I found somebody who could actually glean most of the data back and I lost all the financial data. And I'm sure that that's the situation for some small practices, even now, especially in rural areas.

Roger Holloway, RN, MHA – Executive Director Rural Health Resource Services – Northern Illinois University

This is Roger Holloway. I would just echo the issue I – that we've seen repeatedly is that that kind of Pac-Man approach that we see with vendors out there. I have a standalone midwife. In four years there have been three different owners for the software that she deployed and at each time, she's had the financial responsibility for moving data from the old into the new, because none of those things were ever considered in the contractual arrangement they had. And when you have no margin, you tend to look at products that are the low end, in terms of cost, and unfortunately, many of those are the ones that are most at risk, if they're good, someone's going to buy them and absorb them and if they're bad, you're going to have another set of issues to deal with. So, I think that whole, not just the implementation of the EHR but that selection is so, so important, because it has, as noted here, there are some really big downstream effects from that selection process and the risk, that bigger infrastructure piece.

Joe Heyman, MD – Whittier IPA

So Larry, now you have little understanding of why I'm so sensitive about the increasing cost by increasing regulations and trying to add –

Larry Wolf – Health IT Strategist – Kindred Healthcare

Yeah.

Joe Heyman, MD – Whittier IPA

– things on that are really for third parties, they're really not for the – they're not to improve the relationship between the physician and the patient. They're there for other entities to obtain information, for the most part.

Larry Wolf – Health IT Strategist – Kindred Healthcare

Um hmm.

Roger Holloway, RN, MHA – Executive Director, Rural Health Resource Services – Northern Illinois University

This is Roger –

Larry Wolf – Health IT Strategist – Kindred Healthcare

Go ahead, there's someone else asking a question.

Roger Holloway, RN, MHA – Executive Director, Rural Health Resource Services – Northern Illinois University

I think one of the – it's an important thing, we kind of repeat this over and over. And particularly in rural settings, remembering that about 80% of the healthcare provided is of an ambulatory nature. So if we don't find a cost-effective way to engage small practices and make this easier, not harder, the participation and the value will not be what was anticipated.

Larry Wolf – Health IT Strategist – Kindred Healthcare

Joe, do you want to make any comments –

Joe Heyman, MD – Whittier IPA

And I think –

Larry Wolf – Health IT Strategist – Kindred Healthcare

Do you want to make any comments about other staff in the office that interact with the EHR and whether you had needs for their training or if the app was straightforward enough that you could teach them or the vendor could do something simple that helped with training? Can you help us understand the – yes, you're a solo practitioner, but was there – it sounds like there was at least a front office person involved and maybe some others.

Joe Heyman, MD – Whittier IPA

Right. Actually, in my 14 years in solo practice, I've had one, two, three, four different front desk people.

Larry Wolf – Health IT Strategist – Kindred Healthcare

Um hmm.

Joe Heyman, MD – Whittier IPA

And in each case, I was the teacher. And I was very fortunate, I chose a wonderful EMR for a solo practice and they are still independent, they haven't been purchased by anybody and they're a wonderful company. And it was a very easy to use EMR and I really did not have a lot of problems with training my front desk person. When Meaningful Use came, it became more difficult only because I suddenly had to do a lot of extra clicking in order to record that I was doing things that I didn't – that I would – it slowed me down.

Larry Wolf – Health IT Strategist – Kindred Healthcare

Sure, it triggered the numerators and denominators.

Joe Heyman, MD – Whittier IPA

Exactly. And then, if I hadn't had the IPA, I would not have been able to attest, because we have a woman in our IPA that we call a technical analyst, who goes around from practice to practice and actually helped me make certain that I was getting all that information and that I could attest. And I did attest the first time, the 90-day guy, and I made a decision right after that that I would never attest again, I knew I was going to be retiring in a while and I didn't think it was worth it. And it made it so much easier for me to stop doing all those extra clicks and actually be able to see my patients the way I wanted to see them.

Larry Wolf – Health IT Strategist – Kindred Healthcare

So, interesting question, so, because you know the certification group is looking at non-MU. So we – you continued to use the same EHR but you stopped using the – some of the MU aspects of it.

Joe Heyman, MD – Whittier IPA

Exactly. Right. And I can tell you for sure, it did not affect my quality of care.

Larry Wolf – Health IT Strategist – Kindred Healthcare

Okay.

Joe Heyman, MD – Whittier IPA

I was recording all the same things anyway; I just didn't have to do them in a way that added extra burden.

Larry Wolf – Health IT Strategist – Kindred Healthcare

Sure. Right. You weren't doing this click counts for MU, even though you already –

Joe Heyman, MD – Whittier IPA

Exactly.

Larry Wolf – Health IT Strategist – Kindred Healthcare

– said it somewhere in the note or in the record.

Joe Heyman, MD – Whittier IPA

Exactly.

JoAnn W. Klinedinst, CPHIMS, DES, PMP, FHIMSS – Vice President, Professional Development – Health Information Management and Systems Society

This is JoAnn Klinedinst. Joe, I have a question for you regarding sustainability of the workforce and whether that was addressed in this RAND Study.

Joe Heyman, MD – Whittier IPA

No, because the RAND Study really is about – it's a very interesting thing, the reason they do this study every 10 years is that there's a lot of actual evidence that quality of care is directly related to physician satisfaction and that when physicians are dissatisfied, their quality goes down dramatically. So there's this constant effort to make sure that they're satisfied, and because the AMA is a membership organization, it tries to provide the services that will keep them satisfied. And so by doing this survey, they find out a lot of information about things where they could be helpful, or a state medical society or a specialty society might be helpful. So the study is really about satisfaction, but there's a big section on IT because that became such a prominent issue, which was not even mentioned in the study 10 years ago, about physician satisfaction.

So I gave you some representative samples of things that physicians on our Listserv said, but there are some really insightful statements by physicians within the RAND study. It's both a qualitative study and a quantitative study, so in the qualitative part, they did a lot of focus groups and interviews and there are some very, very interesting statements there, but it's not addressed at workforce. So I had to think about what – knowing what physicians were dissatisfied about, I tried to think of what workforce things might make that better –

JoAnn W. Klinedinst, CPHIMS, DES, PMP, FHIMSS – Vice President, Professional Development – Health Information Management and Systems Society

Certainly.

Joe Heyman, MD – Whittier IPA

– which was how I came up with my list.

JoAnn W. Klinedinst, CPHIMS, DES, PMP, FHIMSS – Vice President, Professional Development – Health Information Management and Systems Society

Okay. Thank you.

Norma Morganti – Executive Director, Health Information Technology Learning Resource Expansion Grant – Cuyahoga Community College

Joe, this is Norma. I have one question for you. We talked a lot in – well in the past at least, about maybe the opportunity for internships or apprenticeships. So, some of those shared resources that you are talking about, do you think that there would be a good opportunity for some type of internship or apprenticeship to be developed with educational institutions?

Joe Heyman, MD – Whittier IPA

I think that's a fabulous idea, Norma, because – well first of all, if we had another person in our IPA that could go around with our technical analyst, learn from that person. But also do some of the, you should forgive me for using the word “scut work”, but that's what we physicians refer to as stuff that we do that really has nothing to do with helping patients, but gets the work done. So, that would be a tremendous help because if – I'm assuming they would be low pay or no pay at the time that they were in their educational mode, and so it would be affordable. And it would also help them, because they could then – there's no question there's a shortage of IT-enabled people, especially in health IT. So, it would enable them to produce people who would be able to help in these situations and they'd have a career afterwards.

Norma Morganti – Executive Director, Health Information Technology Learning Resource Expansion Grant – Cuyahoga Community College

Yeah, so just really getting the internship identified and then having a way for connecting physicians to those, but thank you for your feedback, I think that could be a very interesting aspect.

Joe Heyman, MD – Whittier IPA

So Larry, it sounds like the conversation is pretty much over.

Michelle Consolazio, MPH – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology

I'm not hearing anything from Larry's end. But if there aren't any other comments from the workgroup, Chitra, do we have another meeting scheduled? Do we have next steps?

Chitra Mohla, MS – Director, Workforce Programs Office of Provider Adoption Support (OPAS) – Office of the National Coordinator for Health Information Technology

The next meeting is May 2.

Michelle Consolazio, MPH – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology

And I so I guess, Norma, unless you have any other closing remarks, we can go to public comment.

Norma Morganti – Executive Director, Health Information Technology Learning Resource Expansion Grant – Cuyahoga Community College

I think we're good.

Public Comment

Michelle Consolazio, MPH – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology

Okay. Operator, can you please open the lines?

Rebecca Armendariz – Altarum Institute

If you would like to make a public comment and you are listening via your computer speakers, please dial 1-877-705-2976 and press *1. Or if you are listening via your telephone, you may press *1 at this time to be entered into the queue. We have no comment at this time.

Michelle Consolazio, MPH – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology

Thank you and thank you everybody, both Roger and Joe today especially for your presentations. And have a wonderful weekend everyone.