

## **HIT Standards Committee - Implementation Workgroup**

HIT Standards Committee Hearing on Early Adopters

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Technology Extension Center: Oregon's Regional Extension Center

Clayton Gillett has served as Executive Director for the Oregon Regional Extension Center, since its inception. He has a proven track record in implementing complex health information technology systems with an emphasis on quality improvement, clinician satisfaction and transformative patient experience.

Prior to joining O-HITEC, a division of OCHIN, Mr. Gillett held the positions of Chief Operating Officer and Director of Implementation also at OCHIN (2008-2010). From 2006-2008 he worked as a consultant providing system selection, implementation planning, Stark donation planning, direct implementation support and optimization of electronic health records (EHRs). From 1994-2006 Mr Gillett worked at Group Health Cooperative of Puget Sound in various roles focused on clinical quality improvement and systems implementation.

## Background:

### An Organizational Description

OCHIN is a Health Center Controlled Network (HCCN) providing a hosted implementation of an ONC-ATCB certified integrated practice management (PM) and electronic health record (EHR) system serving 40 separate community health centers (CHCs) across 7 states. OCHIN was formed in 2000 with the intent to provide a world class EHR to safety net clinics. Today OCHIN maintains the HCCN as well as being:

- The regional extension center for Oregon
- A practice based research network providing original research on the safety net population.
- An advanced health information exchange including almost 200 interfaces and an operational near real time exchange of information with EHRs at external organizations.
- A centralized business services division providing all aspects of a clinic's back office billing needs.
- A consulting division offering expert advice on implementation and optimization of EHR systems as well as contract negotiations, system selection and planning.
- A data aggregation and benchmarking tool set designed to provide a normalized set of quality metrics and benchmarks for ambulatory implementations and critical access hospitals. This tool set provides the basis for quality improvement across multiple vendor platforms.
- A center for the education of health care and IT professionals on practical methods and techniques for performance improvement.

In 2011 OCHIN will support more than 2 million outpatient visits and grow beyond 50 organizations. OCHIN has more than 100 FTEs and an annual budget exceeding \$20 million dollars. As a not for profit 501C3 OCHIN pioneers the best and most innovative use of information and information technology for the medically underserved. We remain committed to our vision of transforming the delivery of health care.

## Outline of Oral Testimony

*Identify your challenges, barriers, and successes when providing services (for RECs) or using the implementation support (for REC users) from a Regional Extension Center.*

Oregon has long been a pioneer in the implementation of EHRs and in financing healthcare reform. More than 65% of providers in the state already report using an EHR. OCHIN, the independent practice associations (IPAs), large integrated delivery systems and a history of EHR development in the Northwest have all contributed to this accomplishment. This is a great success but it also poses unique challenges for providers in the state of Oregon. In many ways Oregon is where some states will be in 3-5 years.

### **Barriers:**

Providers who have implemented systems in the past have invested heavily in the infrastructure and systems locally. This helped to mitigate the risk of being an early adopter and provided greater control of the systems. The technology trends and the relative maturation of the market have undercut these decisions. Providers have underestimated the technical requirements of these implementations and the level of staff required to support them. The trend across all industry is moving towards the cloud and away from local implementations. This allows for a standardized build and economies of scale that can't be replicated locally. Even small hosted solutions supported by the IPAs are struggling to compete with the pricing and economies of scale that can be leveraged by vendors offering nationally hosted solutions. Not all providers are convinced that a hosted solution is most cost effective as a total cost of ownership even in small practices and small ASP solutions. In the end this misunderstanding is a large barrier to the success long term of the federal incentives.

In the paragraph above the maturity of the EHR market is referenced. In the ambulatory setting the large number of vendors suggests that the market is far from mature.

Stage I meaningful use requirements can be met fairly easily for most physicians in the ambulatory setting that are already on an advanced system. The relatively low expectations in the ambulatory setting are a barrier to achieving membership goals of the regional extension center for those already on an effective system. This is also a barrier because it is important to have these kind of participants in the extension center to demonstrate that adopting an EHR system can be effective for the physicians. Expectations for Critical Access Hospitals (CAHs) are much more difficult to achieve given the products that are available and resources at each institution.

Providers who have experienced the implementation and use of these systems recognize that the real transformative value of these systems come when providers have learned to use them well, meaningfully. However, the trend towards cloud computing and the financial pressure on rural practices have pushed providers to believe the vendors when they say that they guarantee meaningful use. This belief is a barrier to the signup of extension center members and reduces the perceived value of extension center membership. Furthermore for those on systems already, the stage I bar and the proposed stage II bar for meaningful use are set so low as to discourage a sustainable REC model.

Cost remains a barrier especially in the rural and CAH settings. The extension center is working with the state and vendors to find a way to provide financing until the incentive dollars are available. The reality is that many of these practices are under financial stress and capital dollars remain an issue. This is especially true for the CAHs.

The cost barrier mentioned above is exacerbated by two other perceptions that are prevalent in the provider community. First is that the incentive dollars will not make up for the lost revenue resulting from reduced Medicaid and Medicare reimbursement. Secondly, many providers do not believe that meaningful use funds will actually flow to them. When funds do begin to flow it should be heavily publicized nationally to resolve this issue.

**Challenges:**

Providers and clinic leaders across all settings are not trained in quality management methodologies and tools. This training is not simple and requires significant commitment of time for the participants. The extension center is focused on this issue and has committed major resources to training leaders and physicians in this area.

In Oregon where 65% of the providers have implemented an EHR system many have not effectively maintained the system on the most current version. This is partially resolved in an ASP or SAS (hosted) solutions. In these settings organizations are not usually allowed to remain on old versions. Regardless of the reason, the need to make multiple major version upgrades is a major challenge for many clinics and the extension center and vendors.

OCHIN has made every effort to engage the IPAs and especially the IPAs that are hosting EHRs to deliver direct assistance through local organizations. While this has been a success the challenge has been the extremely long time line required for these groups to make a decision.

**Successes:**

In Oregon OCHIN has more than 15 FQHCs, 2 RHCs and 3 County Health Departments providing services with eligible professionals that will be able to meet stage I meaningful use by March 1<sup>st</sup> 2011. This is a success that exemplifies the hard work of the OCHIN collaborative.

Oregon also has several hosted EHR solutions with more than 100 providers that will also be ready for MU attestation in the next 6 months. These are the groups that invested early in the EHR technology and have been working towards it for some time.

In Oregon some providers who have already implemented systems are taking the opportunity of the incentive dollars to replace their current systems. In many cases these providers purchased low cost or what turned out to be underperforming EHRs with the belief that they would serve their ongoing needs. Implementation and use have revealed that some of these systems do not provide the functionality they need as advanced EHR users. To these providers the incentive program is an opportunity to purchase a system with greater capability and flexibility. This is a great success of the policy.

Oregon is building tight relationships between the extension center, IPAs hosting EHRs, medical societies, Medicaid and the state HIE committees to promote a culture of improvement that encourages the sharing and spread of innovation. The extension center has been successful in aligning the incentives of these groups and has served as a coordination point for policy and more effective communication.

The ONC has been very effective in providing tools to help the extension center understand the complex rules and the legal implications for providers and the extension center. The community of practice (CoP) groups have been especially effective in working out detailed requirements of MU.

*Outline the implementation support and methodologies you used that worked and didn't work. Include any real-world user stories, illustrations, or examples.*

There are many implementation methodologies that are effective and that we, as an extension center, can and have supported. In all of these models the following elements are critical:

- A clear idea of the goals of the implementation prior to vendor selection and measures of success including current performance.
- A sound plan and adequate resources devoted to train the physicians in how to use advanced documentation tools. This requires class room, lab-based, training to augment web based training to ensure that physicians can use and not just understand the tools.

- A plan for the ongoing optimization of the EHR and resources to support participation in ongoing improvement efforts. This is based on the IHI model of rapid cycle improvement.
- A plan to utilize or develop effective clinical measures and operational metrics for financial, clinical, patient satisfaction and provider satisfaction with the system.
- We are collaborating with the medical home initiatives in the state to develop standardized metrics in support of these systems. The medical home initiative provides another focal point to the integration of community quality improvement through collaboratives.

For practices already on a system we begin the process with an evaluation of current performance on MU and other critical quality improvement already in process at their practice. This leads to a list of improvements necessary to meet MU and list of services that they are interested in from the extension center. A project plan is created from this analysis to help assure execution in outgoing months. Each area where the practice is not meeting MU results in a detailed workflow analysis and comparison to best practice is used to suggest new practice methods. The analysis includes the following:

- A review of performance on all 25 objectives.
- A workflow analysis of all deficient objectives.
- A work plan to address deficiencies.
- A work plan to implement additional extension center services (Group purchasing, learning management tools, etc....)

**Experience:**

Hosted EHR solutions are easier to implement and support long term and provide a much easier methodology for sharing data across vendor platforms. This seems a simple issue but is actually a very difficult technical problem. With the advent of medical homes and accountable care organizations it is critical to integrate across multiple vendor platforms.

Centralized comparable practice data for physician, teams and group practices is critical for improvement of the healthcare system.

Standard implementation packages need to include all functionality including and especially, HIE, web services for patients, and population management functions.

Planning for EHRs need to include resources for optimization on an ongoing basis and regular updates to clinical content. Just having the measures and reporting them will not be sufficient to change practice.

*Discuss your outcomes/results. Include any surprises or unexpected outcomes and how you addressed them?*

Practices that have all the tools and an advanced EHR have been able to successfully sustain a quality program with demonstratable results. It is clear that few, if any, EHRs have the reporting tools “out of the box” to provide adequate quality improvement reporting. In most cases significant resources are required to build out the reporting and population management functions.

It has been our experience that some of the FQHCs who chose to purchase and maintain their own “stand alone” solutions are now in the process of replacing those systems as mentioned above. This represents a lost opportunity in the first purchase. Unlike for profits, the FQHCs are being funded by federal dollars for the second time to purchase and implement an EHR.

*Describe your experience using the ONC and CMS communications regarding the meaningful use criteria, standards specifications and measurement.*

Communication on the MU criteria has been adequate from the ONC and the CoP’s have contributed significantly to these communications. The rules appear overly complex which makes it harder to communicate effectively. The lack of consistency between the eligible providers in Medicare and Medicaid as well as differing timelines has served as a constant source of end user questions. Also the lack of consistency between payment rules has made it very difficult for the extension center staff to completely understand and effectively communicate the CMS rules. End users often misunderstand the rules and the intent. When the extension center grant rules are added the complexity is compounded.

CMS specifically has not been as responsive to questions as we would expect and few questions have been answered promptly.

The certification standards are a risk to follow the same path as the past CCHIT standards. In that case the standards were intentionally easy in the first round with the expectation that they would get harder as they progressed each year. The reality turned out to be that the vendors heavily influenced the process and incremental change slowed to the point that the credibility for the certification was lost. It would be helpful instead of a listing of certified, if each certified product had a published score based on the key functional areas. A great example of this issue was the discussion of the update allergy information measure in the MU CoP. In that discussion it became very clear that the different systems (all certified) had very different approaches to allergies. One the patient either had one or did not. The other system could document if it was MD reported or patient reported. It also could maintain the severity of the reaction and intolerances as well as allergies. In a

vendor selection process it is very hard to tease out these issues on the systems you are evaluating even when you are an expert.

**Conclusion:**

In conclusion, successful EHR implementation in the state of Oregon has been based on a standard implementation model focused on quality improvement with additional software development on top of the best systems available. The EHR market is not yet mature and vendors and practices are still learning that a good implementation is more about effective change management than an information technology implementation. In this environment the incentives set up by ARRA and the HITEC laws have the potential to quickly mature the market and implement systems in many underserved and rural settings. If this is to be successful the certification standards and MU requirements need to progress aggressively, driving the vendors and eligible professionals towards greater safety, clinical improvement and patient satisfaction.