



750 West Virginia Street, Milwaukee, Wisconsin 53204

Aurora Health Care is a not-for-profit health care provider and a national leader in the effort to improve the quality of health care.

Testimony to the HIT Standards Committee Implementation Workgroup

Panel 5A: Early Adopters of Meaningful Use Seeking Attestation – Hospital Experience, Part 1 January 11, 2011

Presenter Biography

Nancy Vogt is the Deputy Chief Compliance officer at Aurora Health Care, a large integrated delivery system serving eastern Wisconsin and northern Illinois. She has 32 years experience in health care, in the areas of health information management, electronic health record systems, and regulatory compliance. Prior to her current compliance position, she worked for 19 years in hospital health information management departments, focusing on disease registries, coding, abstracting, and decision support. Following that, she spent 5 years in Aurora's Information Technology Department, where she was a member of the team responsible for the development, deployment and implementation of Aurora's EHR, both in the ambulatory and hospital settings. Following her work on the EHR project, she became the full-time Chief Privacy Officer at Aurora Health Care and was promoted 4 later to her current position as Deputy Chief Compliance Officer. Ms. Vogt has directed the compliance program for Aurora's 30,000 employees for the past 4 years.

Aurora Health Care Profile

- Private, not-for-profit integrated health care provider
 - 30,000 employees
 - 15 hospital campuses
 - 1,400 employed physicians at 155 clinics
 - 82 retail pharmacies
 - Wisconsin's largest home health agency
 - 90 communities in eastern Wisconsin and northern Illinois
 - 92,000 inpatient discharges
 - 2.2 million outpatient visits
 - 3.6 million ambulatory care visits
-
-

January 3, 2011

Members of the HIT Standards Committee Implementation Workgroup:

Thank you so much for inviting me to participate in this hearing. I hope that I will provide information and perspective that will be valuable in your committee's efforts to promote the adoption of electronic health record technology by our nation's health care providers.

My journey into the world of electronic health records began 13 years ago, when I transferred from my medical record department position to my organizations' electronic health record implementation project. I spent 5 years in the trenches, implementing an EHR in both hospitals and physician practices. I spent the next 4 years implementing the HIPAA Privacy Rule as Chief Privacy Officer. Many of our most challenging privacy issues were related to the use of our EHR. Now, as Aurora Health Care's Deputy Chief Compliance Officer, I again find myself spending a significant amount of my time with our EHR – this time working with our Meaningful Use team to interpret and apply the meaningful use requirements.

I admit I was initially reluctant to become involved in the meaningful use effort, thinking the issues to be addressed were technological rather than regulatory. After my first meeting with our Meaningful Use team, however, I immediately recognized the need for the compliance department to be intimately involved in determining whether or not our implementation and adoption meets the requirements for the incentive payments. There were numerous questions not answered by the published regulations, including the commentaries, and not answered by any official FAQs or other guidance. Given the current federal enforcement climate, and given the Office of the Inspector General has already listed EHR incentive payments on their 2011 Workplan, the EHR incentive program has become a top priority for our compliance efforts. We are fully committed to following the rules, but we do not fully understand them.

The intent of the incentive program is to foster and promote adoption of electronic health records, and thus it is paramount that understanding and applying the requirements is not an obstacle to those of us who are ready to cross the Stage 1 finish line.

Q1: Identify your challenges, barriers, and successes as an early adopter of meaningful use seeking attestation.

Aurora Health Care plans to attest to meaningful use in April of this year, which means we are already within our 90-day EHR reporting period. Our early adoption has seemingly placed us ahead of the official guidance we need to determine if we are fully complying with all the requirements. Many of the frequently asked questions posted by CMS are very basic, and do not provide resolution to the questions we are facing.

The earliest challenge we faced was to comprehend what components of our implementation would require certification, and how we would determine if the technology we are using meets the definition of a complete EHR. This sounded simple. We thought our vendor would seek certification and we would implement any updates necessary to use the same version that was certified. It is not that simple.

For example, we want to use our home-grown patient portal to deliver electronic medical record copies to our patients who request them, since we already have patients using our portal for other purposes. The file is created by our EHR; the portal merely represents a delivery mechanism. A discussion during a CMS web conference this past August, however, led us to believe our portal would require certification. Contrary to that discussion, the Final Rule's preamble referred to a patient portal as a form of media, included in the list with CD, USB fob, and Personal Health

Record – none of which would require certification. When we approached an ATCB about certifying our portal, their response was that it would not require certification in their opinion.

We were also hoping to use the data fields and reports that we had already implemented using our certified EHR to meet the requirements for the clinical quality measures. Our vendor, however, used packaged content (which they sell separately to clients) when obtaining certification. Their packaged content and the fields and reports we created all use the same underlying functionality that was certified. After a discussion with American Hospital Association representatives who have had discussions with ONC, we now believe we need to either obtain certification for our fields and reports or else purchase the vendor's packaged content. Our vendor attempted to obtain clarification from their CMS contact, but received a response that we need to use certified EHR technology and no further guidance is available at this time. Spending dollars to purchase content we have already created is difficult to justify, and would require we delay our 90-day reporting period because we would need to start over with our data collection. Our alternative is to spend money obtaining certification of something that arguably is already certified.

We have also experienced some confusion understanding the relationship between the certification and meaningful use regulations. The preamble indicates that certification should ensure that the technology itself is not a barrier to achieving meaningful use, and that certification acts as a floor in terms of how providers may use EHR's. Yet when we attest to using certified EHR technology for providing an electronic copy of the health record to patients, we questioned if we can only count situations where we provided the Continuity of Care Document ("CCD") that was used by our vendor in the certification process. The CCD does not always include all information being sought by the patient, and we have alternative methods to provide information electronically. The CMS Specification Sheet instructs to provide all information that is available, and that the data types listed in the objective are the minimum. Our confusion, though, stems from the vendor being required to use the CCD during the certification process. We are not clear that we are using "certified EHR technology" if we use other available functionality in our vendor's EHR product.

Another certification issue relates to the set of products listed by our vendor as comprising their complete EHR on the Certified HIT Product List. While we do not own all the products listed, we possess the functionality for all the meaningful use measures via this same vendor's products that we do own. We are now, however, unsure that what we own meets the definition of a complete certified EHR. Will we need to purchase additional products because the vendor chose those products when seeking certification?

To date, I have researched and documented more than 35 questions related to the meaningful use objectives and measures. One example with significant ramifications is related to clinical quality measures. The Final Rule's preamble is confusing in that it states, "we will only require hospitals to submit that information that can be automatically calculated by their certified EHR technology. Thus we will require no separate data collection by the hospital, but require submission solely of that information that can be generated automatically by the certified EHR technology..." The regulation itself, however, requires attesting to the accuracy and completeness of numerators, denominators, and exclusions. There seems to be an assumption that if the certified EHR technology includes the fields to capture the data necessary for the calculations, those fields are being populated by clinicians. That is not necessarily true. Even after using an EHR for 10 years, physicians continue to dictate H&P's, op reports, and discharge summaries. In other words, not all the needed data elements are captured in discrete fields that can be used in calculations. It seems incongruent that this objective would require advanced use of EHR technology when the other objectives require the basics that would be expected of early adoption.

The only immediate alternative for our organization is to hire abstractors to retrieve the information from transcribed reports and re-enter it into discrete fields in the EHR. I submitted a question to CMS to confirm that abstracting would meet the requirement, but have not received a

response. This seems like a step backward rather than a step forward. Over time, we expect clinicians to directly enter more and more discrete data, but this is not something typical for early adoption. In fact, physicians documenting directly into hospital EHR is likely one of the most difficult challenges hospitals face. What is more concerning to us are the requirements for some of the exclusions that presume that clinicians document the reason why something was not performed or not ordered. For example, the Discharged on Antithrombotic Therapy measure includes a denominator exclusion for patients with a documented reason for not prescribing antithrombotic therapy. While clinicians are trained to document what was done, it is not typical to document why something was not done.

Q2: Outline the implementation approaches and methodologies you used that worked and didn't work. Include any real-world user stories, illustrations, or examples.

When meaningful use questions have been raised at Aurora Health Care, I have researched them using the regulations published in the Federal Register as well as FAQs and other guidance posted on the CMS and ONC websites. I have attended CMS and ONC web conferences. When I have not able to obtain a clear answer, I have sought the advice of my organization's internal and external counsel. With these regulations being untested, they can only read the same information that I have read to see if they arrive at the same conclusion. While this does not afford us much confidence, it at least serves to prove our diligence in trying to accurately interpret and attest to the meaningful use requirements. Should we be audited and found to have not accurately interpreted the regulations, we would be at risk for returning the incentive payments but hopefully would not be adjudged guilty of intentional fraud or willful neglect.

For those questions where I could not find a substantive answer, I have submitted the questions to ONC and CMS. In addition, I continue to routinely review listserves and compliance blogs, and have participated in discussions with the American Hospital Association and the American Health Information Management Association in an attempt to get our questions answered. I would estimate I am spending 15 hours per week researching meaningful use and documenting our interpretations, and we have spent tens of thousands of dollars on attorney fees.

I called the new EHR Information Center and asked our top four questions. I was transferred from Level 1 to Level 2 support, re-explained the four questions, and was then told my issues required Level 3 support. I am awaiting a call back from the Level 3 support staff.

Q3: Discuss your outcomes/results. Include any surprises or unexpected outcomes and how you addressed them?

Even after my diligent attempts to obtain clarification, I will feel at risk when I attest in April unless the EHR Information Center can affirm or clarify our interpretations of the regulations. Meanwhile, we bear the risk that CMS or ONC could publish an FAQ at any time that might derail one of our existing interpretations, and cause us to start over for a given objective or measure. I am unclear what the protocol will be if such guidance would be published after we have already attested.

Q4: Describe your experience using the ONC and CMS communications regarding the meaningful use criteria, standards specifications and measurement.

To date, I have submitted 21 questions to CMS via their FAQ website. They have marked 10 of my questions as "solved" even though I have only found a published answer to 1 of the 10. I have submitted 8 questions to ONC, 4 of which have been answered by published FAQ's. I suspect that some of our questions are too organization-specific or technology-specific to rise to the level of a useful FAQ. I further suspect that many organizations have not yet arrived to the point where

these specific questions arise. As already mentioned, I now await the EHR Information Center's response to 4 of my questions.

EHR technology and implementation is complex and variable. It is unlikely the current FAQ process and published specification sheets will accurately address all the specific and detailed questions that arise once an organization prepares to attest. There is a critical need for more clear and expansive guidance and perhaps more flexibility. The EHR Information Center needs to have the knowledge and authority to answer organization-specific questions. In the absence of this, eligible hospitals and eligible professionals need to be assured they will not face repayment obligations or enforcement action for doing their best to interpret the regulations.

In closing, I would like to emphasize that my organization and many other health care providers and systems are enthusiastically pursuing the benefits that EHR's offer to our patients. We are grateful for the financial incentives, which will help us to further advance our technology and adoption. We need more assistance, however, to ensure we can confidently attest to meaningful use.

Again, thank you for the opportunity to participate in this hearing.

Respectfully,

/Nancy Vogt/

Nancy Vogt, RHIT, CHC, CHP
Director/Deputy Chief Compliance Officer
Aurora Health Care
(414)299-1712
nancy.vogt@aurora.org