

Testimony to the HIT Standards Committee Implementation Workgroup
Early Adopters of Meaningful Use Seeking Attestation – Hospital Experience

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Members of the Workgroup and Co-Chairs Johnson and Murphy, thank you for the opportunity to provide testimony to your workgroup as a member of the hospital community. My name is Chuck Christian and I am the CIO at Good Samaritan Hospital in Vincennes, Indiana; a role in which I've served for the past 21 years. I am a Fellow and Charter Member of CHIME (College of Healthcare Information Management Executives) and a past member of the CHIME Board of Directors. I currently serve as the Vice-Chair of the CHIME Policy Steering Committee. I am a Fellow of HIMSS (Healthcare Information Management Systems Society) and am the Past Chair of the HIMSS Board of Directors. I am also serving as a member of the Board of Directors of the Indiana Healthcare Informatics Corporation, by appointment of Governor Mitch Daniels.

Organization Overview

Good Samaritan Hospital (GSH) is a 232 bed community hospital in rural Southwest Indiana. GSH is the sole provider of hospital care in Knox County and the largest acute care facility in a five county region. GSH has been providing care in the Wabash Valley for more than 102 years, serving as a regional referral center for the surrounding critical access hospitals. In addition to the acute care facility, GSH provides comprehensive care via its physician services group, Samaritan Center Mental Health services, Good Samaritan Home Care, Good Samaritan Hospice services, and our outreach clinics. Good Samaritan received Magnet designation in 2009, has been recognized as one of the Best Places to Work in Indiana, identified as a Solucient Top 100 Hospital, and a Most Wired Hospital.

Health Information Technology (HIT) Implementation History

Although I would not consider GSH as being on the leading/bleeding edge of HIT implementation, I would suggest that GSH was early to realize the importance of the appropriate implementation of technology in the effective and safe provision of care. GSH began its clinical automation journey in the early 2000's with the implementation of clinical documentation, pharmacy automation and unit-dose medication barcoding, and bedside barcoding during the medication administration process. These and other areas of HIT implementation were selected in partnership with the GSH Medical Staff as areas that would improve the care process and create a safer environment in which to deliver high quality care. GSH continues its HIT implementation journey with the recent kickoff of our CPOE initiatives.

GSH has also been an early implementer of Health Information Exchange (HIE) technology, being the first hospital in Southwest Indiana to connect to the Indiana Network for Patient Care (INPC) and the Indiana Health Information Exchange (IHIE). Taking advantage of the robust HIE infrastructure available in Indiana, GSH is able to provide its medical staff and other care providers a much more complete view of their patient's current and past clinical information.

Challenges, Barriers, and Successes

- Successful incorporation of HIT into a clinical setting is not so much about the implementation of new systems and/or applications, but is more about the process change that is required to ensure that the desired end results have been obtained and new opportunities for error have not been introduced. A key challenge is the associated change process that must be incorporated into the implementation process and the identification of key metrics of success.
- One of the key challenges for GSH, specific to Meaningful Use, has been determining the true definition and explanation of the specific measures. There have been multiple clarifications; however, the clarifications themselves interject additional decision points, creating the need for additional analysis, consuming precious resources during the process.
- Most organizations have not implemented all of their clinical applications from a single vendor; many have a heterogeneous grouping of applications, integrated in the appropriate manner. With many vendors only seeking certification for their systems as a complete EHR, this presents a problem for those healthcare organizations (HCO) that do not own or have not implemented a single vendor complete EHR solution. The only apparent solution would be for the HCO to seek on-site/self-certification or hope that the vendor would be willing to shoulder the expense of getting each module of their EHR certified (unlikely due to the associated expense). With certification being a primary requirement, some HCOs may be left with no alternative but to reassess their position and strategy related to successfully meeting the established timelines.
- The compression and collision of the timelines for Meaningful Use along with those for ICD-10, EDI-5010, and the just now being identified requirements of Healthcare Reform are putting a significant strain on the available qualified resources, especially in the rural communities where these types of resources are in very short supply. With the Stage 1 requirement just now being fully understood, based upon my conversations with other CIO leaders, there is some apprehension surrounding the Stage 2 and 3 requirements and their associated timelines. We are all seeing a decrease in the availability of qualified staff within our vendor's organizations; raising the question as to the industry's ability to successfully respond to the growing demand.
- Many sole-provider facilities have embarked on a community-wide EMR (Electronic Medical Record) designed to create a more complete clinical record and history for the population they serve. In some cases, the national initiatives run counter to those already underway locally and have created confusion in the medical community as to the most appropriate and cost effective approach. The ability to provide a clear direction will allow the leadership to move the community forward toward that common goal.

- One substantial challenge that all small and rural community hospitals face is the one of limited resources; both capital and human. Although the Meaningful Use Incentive Program will provide a much needed source of funding, most organizations our size (and smaller) will need to spend a much greater amount to implement the level of technology necessary to meet the stated objectives of Meaningful Use. And the hope of funding will only materialize after the work has been accomplished, successfully documented, and reported.
- The most significant challenge that I'm confronted with in our efforts related to the Meaningful Use Measures is that of the Quality Reporting requirements. While many/most of the quality measures have been reported by GSH for many years, none are being generated from within our EMR. The numerators and denominators that are used in the current calculations and reporting are gathered manually during retrospective clinical documentation review. Although the certification criteria requires the application vendor to have the capability to electronically gather and report the quality measures, there is a significant amount of internal clinical process that will need to be changed in order to capture the data elements in the appropriate data fields required for reporting. The fact that an application/system has the capability to generate the required numbers for attestation, in no way guarantees that the implementing organization has successfully captured the data correctly. There will need to be new audit/review functions created to verify that the information is being accurately input in a timely manner, adding yet another layer of oversight complexity, while adding little value to the overall care processes. There is also the concern that future penalties may surface if an unintentional calculation/reporting error would be identified during an audit process.
- Please note that the successes that Good Samaritan Hospital has experienced are due to a long process with a focus on designing the future of how we provide care to our community. I do not believe that our experiences can be considered as routine/normal for mid-size and smaller facilities. At GSH I wear many hats due to our size and service area; however, I am fortunate to have a great team behind me. In smaller facilities, the IT departments are much smaller and the spectrum of responsibility and effort ranges from management duties all the way to pulling and installing network cable. In many critical access hospitals, they have to depend upon the talents and services of outside expertise, as they cannot afford to employ certain positions on a full time basis. In my conversations with smaller facilities, there is a concern that they will not be able to retain the level of expertise that the identified efforts will require.

Implementation Approaches and Methodologies

- Our journey toward meeting the Meaningful Use standards is more of a continuation of the IT Strategic plan that has been in place for several years, rather than the need of course correction; however, we have seen the need for timeline compression in order to meet the established Meaningful Use timelines. Our IT planning process includes opportunities for adjustment on an on-going basis, taking into consideration both internal and external influences; allowing us the flexibility to adjust and meet newly identified demands/requirements, while at the same time working against the plan.

- During the mid-90's, GSH identified a core-integration approach of system/application implementation. At that time there was no clear leader in HIT industry and clinical automation was available with limited functionality on a commercial scale. GSH identified an application that could be used as a tool-set in the implementation of best practices in the clinical processes. With the creation of internal partnership of the clinical experts and the application experts, GSH has been successful in implementing HIT in the clinical setting that has improved our ability to safely care for our patients.
- Seeking a more formal method for involvement our physicians with the HIT processes, a subcommittee of the medical staff was formed, the Health Informatics Committee (HIC). The medical staff committee functions as any other medical staff section and reports up to the medical staff leadership, the Medical Staff Executive Council. The HIC is physician lead with membership from all of the medical specialties. The HIC provides a forum for the physicians to act as consultants and provide guidance related to the clinical applications. The HIC also provides a method for the physicians to take a leadership role in the direction and implementation of HIT at GSH.
- Our only failure in clinical automation has been in the Emergency Department. After considered review, a variety of items were identified for the failure:
 - The physical space was not designed for the current patient volumes
 - Since this time, the Emergency Department has been fully renovated and expanded to accommodate the current and expected future patient volumes.
 - The clinical and patient workflows were not well studied and could not be standardized
 - Working with the ED leadership (both physician and nursing) the clinical workflows have been reviewed and standardized where appropriate. Patient workflow adjustments were included in the renovation of the department.
 - The application presented challenges due to design and functionality which created unnecessary complexity in the clinical documentation process and associated workflows
 - The application has matured and the integration with the other clinical applications has improved and will be re-implemented beginning early 2011.

Outcomes / Results

As I mentioned in my earlier remarks, the implementation of HIT alone will not, in itself, generate positive outcomes or results. In my humble opinion, it is only with the associated process re-design and the incorporation of the identified best practices, will positive outcomes be found. Good Samaritan Hospital's market is currently approximately 60% Medicare and 10% Medicaid, creating a reimbursement environment that is strained, at best. However, in that market GSH has been successful in providing very high quality, safe care to the communities we serve and in maintaining the cash flow necessary to meet the community needs and fund the appropriate future growth of the organization. I would like to believe that the incorporation of HIT has played a role in my organization's ability to fulfill its Mission and Vision. However, I do know that it is through the partnership of a professional and very dedicated clinical community that we continue to be successful in that quest.

In our market we have seen an increased interest and urgency in acquiring and implementing EHR's in our community physician practices and providing the connectivity provided by the HIEs that service our market.

Experience with the ONC and CMS Communications

In my humble opinion, I believe that both CMS and ONC have made significant efforts to make certain that the necessary information is flowing from as many streams as possible. Drs. Blumenthal, Mastashari, and Hunt have been very much willing to reach out to collaborate and accommodate open discussion/communication. I'd had the privilege of being engaged with both CMS and ONC via my roles with the CHIME Policy Steering Committee and the AHA Health IT Advisory Network; therefore, my experience may not be an appropriate standard.

That is not to say that all communications have been exceedingly clear and concise. As I mentioned in my earlier remarks, some of the clarifications have created "opportunities" of additional analysis and decision points. Most of the clarifications have been helpful in moving the process forward; however, many of the clarifications themselves are still open to interpretation. I realize that with the variations within healthcare organizations, it would be far more disruptive to attempt to dictate a cookie-cutter approach for the task at hand.

I encourage both CMS and ONC to continue the level of communication with the healthcare industry in general and to seek to engage the CIO community at a more granular level.

I would like to thank CMS, ONC, and the HIT Standards Committee Implementation Workgroup for creating opportunities for individuals as myself to provide information and feedback through forums such as today's discussions and the public comment periods. I would also like to thank all these organizations for carefully listening and making adjustments where appropriate and holding firm where necessary in order to maintain the course and direction of HITECH.

In Closing

Thank you again for the opportunity to provide testimony on these topics, I'm hoping that my comments will assist in your very important work.

Respectfully submitted;

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