

Main Line Health Testimony to HIT Standards Committee Implementation Workgroup

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Introduction

Main Line Health is an integrated healthcare delivery system in the Philadelphia Suburbs, consisting of 4 acute care hospitals (Lankenau, Bryn Mawr, Paoli and Riddle Hospital), two rehabilitation hospitals (Mirmont and Bryn Mawr Rehab), and a multi-specialty physician network of approximately 250 physicians in 50 practices. The Main Line Health medical staff also includes approximately 2000 independent physicians.

Three of the acute care hospitals use the Siemens Soarian EMR, and one uses the Cerner Millennium EMR. All are in position to qualify for Meaningful Use in 2011.

The physician network uses the NextGen EMR, for both practice management and EMR. Many of these practices will be in a position to qualify for Meaningful Use in 2011.

The independent practices are implementing EMRs of their choice – and we see a wide variety of EMRs in this group. Main Line Health supports these practices by offering discounted rates on the eClinicalWorks EMR. Many practices are signing up to this program and expect to qualify for Meaningful Use in 2011 and 2012.

Main Line Health has an enterprise HIE, using MobileMD as connectivity partner. Connected practices, with a wide variety of EMRs, are receiving lab, radiology and transcription. Order communication is planned for 2011, and CCD exchange is also scheduled. If and when a state or regional HIE emerges for our area, Main Line Health plans to use MobileMD as the connection point into this wider HIE.

Main Line Health is asked to testify in Panel 4, for Eligible Providers. Since our organization also includes hospitals, some of the challenges and successes apply both to the hospital as well as eligible provider experience.

Question 1: Challenges / Barriers / Successes

Challenge: timing of stages and releases

The time between the final version of the requirements and the actual implementation is tight. Vendors require us to update our software to their certified versions, just prior to

qualification – and then implement the new features that are required to meet MU criteria. For Stage 1 we’re going to meet the MU requirements in 2011. We’re concerned that the time between the Stage 2 Final Requirements, and the vendors delivering the versions supporting Stage 2 requirements, and the providers needing to implement these, will be too tight. We request a longer runway to Stage 2, allowing more space from final requirement definition to implementation.

Challenge – many independent practices still in “selection” mode

The majority of independent practices are still in the selection phase for their EMR. The Main Line Health supported EMR program has galvanized many of these practices to start their implementation in 2011. Some of these may meet MU requirements in 2011, and others will get there in 2012. We also see a large number of practices who are still not actively pursuing EMR projects at this point.

Challenge – overlap with other existing data submission requirements

MU Quality Measures overlap with a number of other quality reporting systems. We realize that there was an attempt to coordinate the MU Quality Measures with existing Quality Measures (PQRI, CMS/JCAHO, etc.) – but these reporting requirements still exist, and our organization now needs to report to these bodies in addition to the MU Quality Measures. We request and recommend that the committee helps lighten the load by consolidating measures and reporting mechanisms. This should include state requirements, for example Pennsylvania Act 52 requiring data submission for hospital infections.

Many of these reporting requirements use paid intermediaries for data submissions – adding a significant expense to the health system and to healthcare overall. We request and recommend that quality reporting requirements are either federal, or standardized between states, and require no paid data submission intermediaries.

(For illustration – one of Main Line Health’s data submission intermediaries charges \$400K per year for one state reporting requirement)

Challenge – State Submission requirements

For the immunization submission requirement and the syndromic surveillance requirements, we recommend to the committee to implement standard methodologies and data sets for submissions. These are currently different for each state – and sometimes cumbersome and prohibitively difficult to implement. For example, to transmit immunization data, Pennsylvania requires that if you submit any immunization data, the practice must submit all immunization history – which the practice may not have, or would be very time consuming or costly to gather and enter. We recommend that state reporting requirements are standardized, or centralized in one federal or CDC-administered reporting mechanism.

Challenge – Quality Measures require data which is unstructured

Many of the quality measures require data which is currently captured in unstructured form – both for the hospitals as well as for EP's. As a health system, we are either changing our documentation templates to capture the required data in structured form, and/or implementing Natural Language Processing methods, which are both expensive and imprecise.

Challenge – Quality Measures require individual reports

Some EMR vendors include the standard reports for Quality Measures. Others don't provide standard reports, and leave it up to the practice to create and manage these reports. For smaller practices, this is a significant undertaking. While that's not something the HIT Standards Committee can fix, the best approach may be to maintain the current set of quality measures, and not create many more for Stage 2. The hope is that vendors would create model reports once the total set of Quality Measures remains relatively stable.

Question 2: Implementation approaches / methodologies

For both the hospital as well as the physician network, Main Line appointed a Meaningful Use Program Manager, who drives the overall project. Several project managers report to the Program Manager to drive the individual projects.

On the hospital side, each MU criterion has a Business Owner who is responsible for the operational and IT implementations to meet their MU requirements. The team uses a project dashboard fashioned after Judy Murphy's example from Aurora – we express our thanks to her!

On the physician network (EP) side, rather than dividing it by MU criterion, we divide the project by practice, and each practice has a Practice Owner, who is responsible for the overall project within the practice.

For the EP implementation, we used several strategies for successful rapid implementation:

- All Practice Management components were installed and live, all on the same date.
- Rapid rollout of ePrescribing and electronic ordering is very successful – minimal training is required, and physicians adopt ePrescribing and electronic ordering without much difficulty.
- Physician Documentation in the EMR is a more difficult component, and training and rollout of Physician Documentation is the slowest component in the EMR adoption. This requires the biggest change in the practice workflow.
- Even though the functions are rolled out over time, we purchase and install all the hardware and workstations up-front. This helps in the later rollout – the practice team is used to having the equipment ready and available.

- While Main Line attempts to implement one standard documentation template for all practices, we do allow a limited amount of customization between practices, adapting to their patient mix, provider mix, roles and responsibilities. These changes are necessary, but do take some more time in the rollout to a large number of practices.
- In the initial training and rollout to practices, we specifically introduce and explain ARRA and Meaningful Use criteria – making the entire team aware of the challenges and rewards, and raising awareness of the importance of these requirements, both for patient care as well as for the organization.

Question 3: Outcomes / Results / Surprises / Unexpected Outcomes

For the Main Line Health Physician Network, we prioritize practices with significant Medicare patient volume to qualify them for the Meaningful Use criteria, and those with lower Medicare rates follow later. We plan to have the majority of the high-Medicare practices up on Meaningful Use by 2011 and 2012. The main challenge is speed of training and rollout of Physician Documentation.

For the independent EP's, there is a wide range of statuses – from currently ready for Meaningful Use, to totally on paper and not ready to start, and everything in-between. Main Line Health is offering assistance through a discounted EMR, which is getting very strong interest and will have many practices in implementation in 2011, and ready for MU in 2011 and 2012.

Main Line Health has limited experience with the Regional Extension Centers. We have met with our local REC team, which is well-run and well-staffed. They are active in a few practices, but we would like to see the REC teams active in many more practices.

Question 4: Experience using ONC and CMS communications

Main Line Health receives a lot of helpful information and recommendations through the various EMR software vendors – Siemens, Cerner and NextGen.

We have used the new website, which was released in the past 2 weeks. While this provides us with a lot of information, we'd like to recommend to the committee to create a cross-walk between the provider MU Requirements (both Hospital and EP), and the vendor EHR certification criteria. Often we need to refer to both to get the full specification. In some cases, the EHR certification criteria contain more implementation specifics than the provider MU specifications – which prompts us to use both documents for the full specification. A crosswalk or single requirement would be very helpful.