

## Panel 4. Eligible Providers' Experience

---

### *Careen Whitley, MD*

I am pleased to participate in this hearing as a practicing physician using a certified EHR, and a member of Hill Physicians Medical Group ([www.hillphysicians.com](http://www.hillphysicians.com)). Founded in 1984, Hill Physicians is one of the nation's largest independent practice associations (or IPAs). Hill represents more than 3,500 physicians and healthcare providers. We currently care for 332,000 patients through HMOs, Medicare Advantage plans and Medicaid, although the total number of patients cared for by Hill providers is much greater. Our member physicians practice at approximately 1,600 office locations and work in 30 hospitals and 15 urgent care centers throughout 10 counties in Northern California.

Within Hill Physicians Medical Group, I am a family physician in private practice in Oakland, CA for the last 25 years. I currently employ another family physician, a physician assistant and a nurse practitioner in addition to 6 ancillary staff. We provide care for families "from the cradle to the grave." I still deliver babies and make home visits for my geriatric or hospice patients.

Hill strives to support its individual physicians in their efforts to improve clinical outcomes and increase efficiency. As a result, Hill Physicians has consistently been recognized as one of the top performing groups in the Integrated Healthcare Association's Pay for Performance Program in California.

From its early days, Hill has been dedicated to using information and information technology to provide medical care to its members. One of Hill's early ventures was to partner with RelayHealth. This allowed physicians to communicate electronically with patients, as well as colleagues, using a secure messaging system. This service has been expanded to include:

- ePrescribing with formulary checking and drug interactions
- online lab results reporting which can be shared with patients
- HIE functionality with several local hospitals

Today, virtually all of our providers are enrolled with RelayHealth through Hill and about one-third actively use the service for secure messaging. More than two-thirds of Hill's HMO members are enrolled with RelayHealth for secure communication with their Hill providers.

In 2004, Hill recognized the importance of promoting the use of electronic health records as a stepping stone to improving quality and efficiency. To that end, Hill licensed an enterprise-wide EHR from NextGen Healthcare with the intent not only to sublicense the system to its physician members at a steep discount, but also to serve as the main point of contact for EHR implementation, training and ongoing support services for its physicians.

Hill Physicians chose NextGen Ambulatory EHR for a number of reasons. First, it was a stable company that we felt would be in the market for a long time and would mature as EHRs advanced. Secondly, it provided both primary care and specialty content. Thirdly, despite its complexity, the EHR seemed fairly intuitive and could be easily navigated with some basic instruction.

We are very proud that today we have 255 providers in 77 practices (96 locations) using the Hill EHR to serve over 81,000 Hill patients, and with almost 800,000 patients in the EHR database. Hill anticipates a 30% growth in EHR adoption in 2011. Both RelayHealth and NextGen Healthcare have been invaluable partners throughout our HIT adoption and we expect our relationships to strengthen as we move through the Meaningful Use process.

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

Although the final rule is much less stringent than what was originally proposed, I am concerned that the task at hand remains fairly daunting. While individually the measures seem attainable (some requiring more work than others), meeting **all** measures to receive payment is a very demanding goal. Having participated in previous demonstration projects, such as MCMP and PQRI, the bar for Meaningful Use is considerably higher.

Also, while I have no doubt that providers, with appropriate effort, can meet the objectives, reporting is a burdensome, albeit, necessary task. First, it involves not only collecting the data but making sure it is documented in the correct fields. In many cases, documentation will require extra steps and thus more time from providers, thus increasing the administrative burden and not improving quality of care. Lastly, providers or their staff are tasked with extracting that information to report to CMS, another labor intensive process. It is not clear to what extent the Hill organization can facilitate this for our EHR practices.

One barrier to physician participation is physician distrust of government and CMS in particular. Many who participated in PQRI have been very disappointed in payment for their efforts. Many experienced significant delays or never received payment. Very few felt they were adequately reimbursed for the effort involved. Also, explanations of how payments are calculated have been slow in coming and impossible to decipher and gain meaningful insight as to how to improve future performance. There is also the perception that Congress will rescind funding for Meaningful Use or that money will run out before providers are able to qualify and their efforts will have been in vain.

An additional challenge is that, although the NextGen Ambulatory EHR was one of the first certified for Meaningful Use, the certified application software is only now being released for general use. As a result, we have not yet installed the required updates. I think this committee should be mindful of the fact that this is true of many - if not all -

EHR vendors because of the extremely short timeline from when the final criteria was released (July 2010) to when providers could begin to qualify for incentives (January 2011). And while I understand the pressures that vendors have been under to produce a quality product, this still leaves our organization unprepared to meet the expectations of our users.

It has been our experience that it takes several months of testing before we can release the new software version to our EHR users, so we do not expect to be fully ready to report for meaningful use until late spring or early summer of 2011. I and other Hill EHR support staff have been actively following the legislation over the last year in preparation, but it is stressful sitting on the sidelines, waiting for the tools needed to participate. While we as an organization recognize our providers do not have to qualify in 2011 to receive full benefit financially, many of our EHR providers are anxious to do so and are impatient with having to wait. Having invested in an EHR, they want the benefit of receiving the first portion of the incentive as soon as possible.

Over the last 6 years, we have also found the complexity of an EHR to be far greater than we would ever have anticipated. Although we expected this to be a work in progress, we never realized how much that would involve. As an organization, Hill has a fairly large IT staff to support the ongoing work to make our EHR successful. This staff will also ensure that all our providers are able to successfully become “meaningful users.” It is hard to imagine that a small physician office would be able to accomplish this on their own with their limited resources.

One final area of concern relevant to California based groups, such as Hill Physicians, is the Medicare Advantage issue. In the final ruling, “payments are made only to Medicare Advantage organizations that are licensed as HMOs or in the same manner as HMOs, by a state. These Medicare Advantage organizations may receive incentive payments by way of Medicare Advantage affiliated hospitals (MA-affiliated hospitals) and Medicare Advantage eligible professionals.”

Further, eligible professionals must be “employed by, or partner of, an entity through a contract with the Medicare Advantage organization, that furnishes at least 80% of that entity's Medicare patient care services to enrollees of the MA organization. Also, Medicare Advantage eligible professionals must furnish at least 80% of their Medicare-related professional services to enrollees of the MA organization and must furnish, on average, at least 20 hours per week of patient care services.”

Hill providers care for Medicare patients through both traditional Medicare products, as well as, Medicare Advantage programs. For many practices, a significant portion of their Medicare patients come through Advantage contracts held by Hill Physicians. As such, they do not meet the requirements outlined above and thus are only able to report on traditional Medicare patients. These practices are squarely at a disadvantage and may not be able to receive incentives at all. This is also a dilemma for other providers in the state of California working through other large IPAs and has been discussed at many state-wide organizations, such as CAPG, without resolution.

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

I was fortunate enough to be one of Hill's first EHR pilot sites and in March I will celebrate my 6<sup>th</sup> year on the system. As mentioned above, forcing all the HIT vendors to update their products and achieve certification so late in the year has caused providers to have to wait until now to upgrade to the certified versions. As a result, I cannot yet share methodologies specific to Meaningful Use attestation, but can share many of our approaches and successes with EHRs to-date that has prepared Hill well to meet several of the measures.

The journey from paper to full use of an electronic health record has been bumpy but exciting. My personal interest in the EHR was initially to improve office efficiencies and I would say this is true for many of my colleagues.

Documentation in medicine has always been a problem. Initially, we used dictation which we found very expensive. In addition, there was always a delay of several days from the time of dictation until it was available in the patient's chart. And on occasion, dictations would be lost all together necessitating recreating the encounter from a less than accurate memory. Written notes, as we all know, tend to be incomplete and usually illegible as they are hurriedly scribbled by busy practitioners. Colleagues will attest to frequently missing charts, labs, consult notes, etc. at the time of a patient encounter, thus making the patient visit less than optimal.

Also, messaging in a paper world was extremely inefficient. Patient inquiries or medication refill requests required staff taking accurate notes and retrieving the patient chart. Once a physician reviewed and returned the requested information to staff, it would be returned to the requester. This process took hours and sometimes days and frequently resulted in redundant requests.

With EHRs, these inefficiencies are essentially non-existent. Documentation ideally is done at the point of care or shortly thereafter. Since it is done in the electronic record, there is no need to file. Charts are no longer lost. With a lab and hospital interfaces, tests, consults and other documentation are quickly and easily available and again without misfiling and without delay. Patient messaging appears in the chart and can be addressed efficiently. So I am pleased to say the EHR has easily satisfied these needs.

However, there have been many challenges with HIT adoption along the way. First, physician members of an IPA are very different from employed physicians within a closed system such as Kaiser or a hospital-based foundation organization. Although we have some larger groups, for the most part our physicians exist in fairly small, autonomously functioning practices. Providers are fiercely independent in their thinking and while they welcome the support Hill provides, they have their own governance and

make their own decisions about practice operations, including whether to adopt IT solutions.

As small practices, our physicians are also small business owners. Thus, in addition to providing medical care, they have the pressures of managing employees, a physical plant and financial aspects of practice. These pressures are particularly daunting for primary care physicians, whose salaries are not subsidized (as they might be in a large system such as Kaiser or a hospital based foundation model) and thus compensation tends to be marginal at best. Despite the time spent in patient care, most surveys show primary care physician earnings are significantly lower than their specialty colleagues. The effect of the recent economic recession cannot be overlooked. It has forced many practices to focus more energy on practice management issues, leaving fewer resources for innovation (including IT adoption).

Physician acceptance of the EHR has run the gamut from eager involvement to stubborn refusal to participate. Yet no matter what the starting point, all have found EHR adoption to be one of the most demanding, difficult, and challenging endeavors. Using the EHR calls for a new approach to workflow and documentation, and requires a great deal of energy and brain power while trying to remain attentive to the health and well-being of our patients - which after all is our primary goal.

For many it also involves changing work styles and habits that have been with us for many years. As an example, it is very hard to sit in front of a computer screen and carry on a meaningful interaction with a sick patient – clicking on boxes and typing in text, maneuvering between templates – while maintaining eye contact and showing empathy. Not to mention, the physician is also processing information and developing a medical framework to the patient's problem including making a diagnosis, planning further evaluation and developing a treatment plan. Moreover, it is impossible to physically examine a patient and record the findings electronically at the same time. Somehow this seemed much easier in the paper world. Maybe this was because that is what we were used to.

However, I suspect using technology can be burdensome at times because so much more multitasking is required. As an example, I think we are all competent at jotting down notes while listening to a speaker, however, attending to a computer screen – texting, surfing the internet or reading email – takes significantly more brain resources than any of us would like to admit. When you add to this that the physician is frequently assessing important health issues, I think this parallels the conversations today around texting while driving.

Yet, with time, providers do learn new skills of engagement. They realize that important information about their patient is readily available to them in the EHR. They learn short cuts to efficiently document their findings and start to appreciate the efficiencies of EHR for their practice. They learn to accept not only the unnatural syntax of a computer generated notes but also, the loss of their very individualized and personal style. They

come to recognize that they can provide very efficient medical care and still remember to ask about the family pet.

It should not be overlooked that during EHR implementation, providers are not able to continue at the same level of efficiency. For weeks to months, it is essential to scale back patient scheduling, and as a result there is significant negative effect on revenue. As an example, before EHR, I averaged 35 patient visits a day. During implementation this dropped to 15 and then rose to 20 visits during the next 6 months. Even today, a normal load is 30 to 32 visits and I have no illusions I will return to my previous level of functioning. Although I have accepted that it takes longer for me to document my patient visits, I also appreciate that my patients are receiving more complete care. The efficiencies of EHR are not in time spent by the provider but rather more efficient use of ancillary staff, decreased redundancies, and instant availability of patient data.

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

Even though, at this moment, I would not meet the qualifications of “Meaningful Use”, I can say that using an EHR has taken me down a path of delivering better quality care to my patients and what I can personally and proudly call “meaningful.” As examples, I can:

- Easily address health maintenance at each encounter (tobacco use, obesity, health screenings).
- Monitor disease management goals for patients with chronic conditions such as diabetes.
- Provide my patients with summaries of care at the end of a visit.
- Provide my patients with consistent unbiased health education materials.
- Communicate with colleagues on behalf of our mutual patients.
- Communicate electronically with patients in a secure environment.

These are all areas that I struggled with prior to EHR. Although I am pleased that the federal government and private insurers are realizing the importance, I can proudly say I began working on accomplishing these tasks before ARRA ever came into being.

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

Regarding communication about Meaningful Use from CMS and ONC to providers, I have often found the information either too simplistic or completely overwhelming. Particularly during the early stages of development, the interim rules were complex. There is no way a busy practicing physician could hope to “meaningfully” participate and

comment. The final rule, though much less complex, is still well over 800 pages and I have to admit it is buried under a stack of medical journals I have yet to read.

I think many providers have relied on EHR vendors, local medical associations and our specialty organizations to distill the information for us and provide guidance. However, it is clear at Hill Physicians that our providers are looking to us to lead them through this process and ensure their success. They expect us to keep them updated. They expect the process to be as painless as possible and to have as little impact on their daily office functioning as possible. To that end, Hill is providing ongoing communication with our users and plans to develop a clear plan for the path to Meaningful Use. We will disseminate the information to our providers in numerous ways including regular written communication and more detailed onsite training.

### **Conclusion and Recommendations**

I am amazed at how far my practice and others have come from the paper jungle of just a few years ago to an efficient online patient care setting where all the information I need to treat patients is always immediately available. I can perform these functions securely regardless of where I am – in the office, at home, or here in Washington, D.C. being asked to speak to this committee. I can also securely communicate with my patients and other providers online. Thanks to Hill Physicians and their forward thinking, health information exchange through RelayHealth, has been an integral part of our EHR from its inception.

I have witnessed the struggles of our providers with adoption of EHR and have been impressed with their resilience and persistence through a very difficult process – all the while continuing to provide excellent health care to their patients. This may not be a big deal for today's medical school graduates, but we can never underestimate how difficult this process is for physicians who have lived in a paper world for so many years. Also we should not forget that barriers still exist to sharing information between different EHRs and between providers and other health care systems – hospitals, pharmacies, public health departments, federal agencies, etc.

As this committee and others develops guidelines for Stages 2 and 3, I would like to recommend the following:

It is important to make sure that other entities are motivated and able to partner with providers to be successful. For instance, public health departments need to be able to accept electronic communication from physicians and in a manner that allows our EHRs to talk directly to their systems. Hospitals, pharmacies, imaging centers, labs and other ancillary services need to be incentivized to share data with providers. Barriers to sharing data need to be torn down so that patients do not continue to have duplication of services – this more than anything would lead to huge savings for our health care system. Everyone treating a patient should have access to the same information. There should be a large repository that serves as a resource to all. With proper security, all providers of

health care should be able to view this repository and then extract into their own database, that which is necessary for them to provide quality care to the patient. Kaiser and others, as closed systems, have figured this out. But I see no reason why the rest of us should not develop a system more conducive to the health of our patients. Also, shouldn't information flow between Kaiser and other entities?

In addition, when guidelines are developed and finalized, consideration needs to be given to the time needed for all the required parts to be available to the end user. Obviously, our vendor partners need time for development and distribution of the tools needed. Providers and their supporting organizations then need equal time to make these tools function in their individual environments. Although providers have several years to begin participation, it seems only fair that everyone should start on a level playing field and have all the pieces available to them from the start.

I thank you for the opportunity to share my thoughts with you. As Meaningful Use progresses to stage 2 and stage 3, I hope to have an opportunity to remain involved in this process.