

Meaningful Use Workgroup Hearing
October 5, 2011
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Introduction

Thank you for inviting me to testify today and for your work to further the adoption and implementation the health information technology.

Organization Profile

CMH is a rural healthcare network serving southwest Missouri. The CMH network offers these services:

- Rural, sole community provider hospital with 76 beds,
- Home care services,
- Ambulatory care, including ten certified rural health clinics and eleven specialty physician clinics and
- Long Term Care, including six skilled nursing facilities, one residential care center and eight independent living complexes.

CMH implemented an EHR system to enable a patient to enter anywhere into the continuum of care and have a personal identity that is maintained across that continuum. CMH also works to assure physicians and other caregivers have access to all of that patient's information within the healthcare system.

The CMH EHR system includes one longitudinal record for each patient, including all encounters within the CMH network. CPOE is utilized throughout the system. Paper medical records have been eliminated.

The CMH extensive and successful implementation of the EHR has resulted in this recognition from within the industry.

- HIMSS Nicholas E. Davies Award of Excellence for Health Care Organizations, 2005
- Health Care's Most Wired, Small & Rural, 2005-2007
- Health Care's Most Wired, Top 100, 2008-2010
- HIMSS Analytics Stage 7 on the EHR Adoption Model, 2010

As might be evident from this description, CMH is advanced in our use of the EHR. And, even we have had challenges qualifying for meaningful use. We do recognize from our experience, that the journey is difficult and that other rural organizations just beginning that journey to EHR adoption have much work ahead of them.

Experience with Meaningful Use:

CMH is grateful for the opportunity to qualify for the meaningful use incentives. Assuming that the progression through the stages of meaningful use is kept to a pace that allows all hospitals and eligible providers to succeed, we believe the resulting transformation will be positive for patients and the delivery of health care across our nation.

Going forward the challenge for you, CMS and ONC seems to be to achieve the potential of meaningful use by evolving through Stages 2 and 3 to a model that is simple, clear and administratively manageable for both providers and CMS.

Medicare or Medicaid?

- Hospital - CMH is qualified for both Medicare and Medicaid incentives.
- Eligible Providers -
 - 37 full time primary and specialty eligible providers employed by CMH are eligible for the Medicaid incentives.
 - CMH employs or contracts with an additional 15 providers who work part time at our facilities and for whom we are not pursuing meaningful use incentives at this time.
 - CMH also employs six radiologists and anesthesiologists eligible for the Medicare incentives and subject to the penalties, but for whom we aren't sure how to qualify. These providers use the acute EHR system for their work which is only certified under the acute certification. We have this question pending with CMS and ONC and our vendor is engaged in discussion on a resolution.

When?

- Hospital - CMH attested to meeting meaningful use Stage 1 at the end of May, 2011. We waited to feel confident that Stage 2 will be postponed for those hospitals achieving meaningful use in 2011. Without this change, achieving Stage 2 under an extremely short timeframe would have been impossible.
- Eligible providers – For our eligible providers who qualify for the Medicaid incentive, we are still working with MO HealthNet (Missouri Medicaid) to complete the attestation to validate that we have adopted, implemented or upgraded our EHR technology. We have these issues pending with the registration system, including:
 - Some providers are not recognized by the system. The state is working to resolve this issue.
 - We do not have a way to segregate the patients who qualify for Medicaid under the CHIP program. The state is working to publish a county-level percentage of

CHIP patients that we can apply to our Medicaid percentage to estimate the CHIP patients for each provider.

- The vendor operating the registration site for Missouri has not completed the system for group registration where a group of providers qualifies together. This is expected to be complete in early October.

Easy objectives?

The CMH situation is not common among rural hospitals. Prior to meaningful use, CMH was already a Most Wired Hospital and had achieved Stage 7 on the HIMSS EMR Adoption Model. As such, we found most of the core measures to be relatively easy to accomplish once there was clarification on the requirements for each measure so that those could be certified by our vendor and implemented within our organization.

This will not be true for hospitals just beginning the EHR journey. We implemented our EHR system over a period of years and those hospitals will be expected to accomplish the same levels of adoption in a much shorter time period to qualify for the incentives.

Challenging core objectives?

The CQM's have posed the greatest challenge for our hospital and eligible providers.

Other challenging core measures:

CPOE for eligible providers. This measure is confusing. The measure is for CPOE to be used for one medication for patients who have at least one medication on their medication list. This applies even if the provider reporting for meaningful use didn't personally order any medications for that patient. So, the numerator is not really a subset of the denominator, but a subset of another subset of the denominator. The numerator may not even be in a subset of the denominator at all. This type of illogical measure leads providers to question the validity of the measures in general.

The clinical summary requirement for eligible providers has also posed a challenge, particularly for lab results that are available after the patient has departed the clinic. Eligible providers have processes in place to assure these results are communicated to patients via telephone or letter, but reporting on this delivery of results in conjunction with handing a patient a standard clinical summary at the conclusion of a visit is very challenging.

Challenging menu objectives?

These are the menu items we did not choose to utilize in Stage 1 and why:

MENU ITEM	REASON NOT CHOSEN
Electronic Access	Although we are leaders in the implementation of patient portals and providing information for personal health records, this measure was 1) challenging to report against and 2) challenging to achieve in a rural area.
Summary Care Record	Even with the discussion about this measure in the final rule, we were unsure what transitions of care were included (particularly as it relates to an EP) or what format or content the summary care record should include or how to report that the summary care record was provided. This was surprisingly difficult, especially considering that it is standard practice to provide a summary care/transfer record upon any transfer of a patient to another facility. And, also confusing just because it isn't even a use of the EHR if it can be produced on a paper form.
Reportable Labs for Public Health	We are not aware of a local or state public health department accepting even a test of this functionality in Missouri. We were able to test immunizations and syndromic surveillance reporting.
Patient Specific Education	It is still unclear to us what form of patient specific education is required. Is it standard education about the patient's conditions (such as standard education about congestive heart failure), or is it education specific to what the patient should do after discharge or post visit (such as take your weight daily, schedule a follow up visit with your physician, walk up to 40 feet during the first week twice a day)?
Reminders to Patients	Just reporting on this menu item seemed complex. Would we report that we generated a letter? How would we measure it when we generate multiple versions before we send the actual letters?

CQM's:

The CQM's have been, by far, the biggest challenge in meeting meaningful use. For our perspective as a provider, these measures seem to be 1) premature, 2) non-standard and 3) "unowned."

Premature

- The CQM's used for meaningful use do not appear to have been piloted or field tested.
- The measures do not include any guidance for implementation. Vendors certified for meaningful use for CQM reporting seemed to be getting guidance from certification bodies and we are unclear on how the certification bodies have included experts in electronically specified clinical quality measures.

- The measures include clinical errors. Surely, CMS didn't intend to require clinical quality measures with known clinical errors and no method identified to update and correct these measures.

Non-Standard

- The CQM's utilized a non-standard model and code sets that are not in common use in EHR systems. In particular, the use of SNOMED codes for procedures, exclusions and intent is not in common use and had to be configured. We built queries with these standard codes attached to extract the measure results. These queries are presented to providers and caregivers in the normal flow of work as often as possible. Even so, the likelihood of accuracy (i.e. that the measure result reflects the care provided) seems very low.
- In addition, the reporting for the CQM's using the PQRI XML format doesn't seem to make sense, especially for the hospital CQM's. This format does not appear to be designed for these types of measures and these measures don't appear to have been specified to this format.

Unowned

- The CQM's do not seem to have a measure steward. This is the most concerning aspect of the CQM's. Most quality measures we are used to using are both endorsed by NQF through a robust methodology and have a measure steward (such as Joint Commission).
- We could not find these measures on the NQF site as endorsed measures. The measures that are on the NQF website as endorsed for these conditions are the manually abstracted measures for Stroke, VTE and E D Throughput – not the electronically specified measures required for meaningful use.
- Therefore, there is:
 - No steward to conduct or validate field tests of the measures or updates to the measures.
 - No steward to give guidance on the implementation or use of the measures.
 - No steward to correct errors in the measures.
 - No steward to update the measures as medications change, codes change, or new evidence is confirmed.

The CQM's are potentially the most important aspect of meaningful use. These measures could both drive and document the successes of EHR implementation. **We hope CMS and ONC will “retrench” on the CQM's and require that these measures, and all new CQM's for meaningful use, are endorsed and follow a path that includes field testing, validation and measure stewardship.**

In addition, we encourage the use of CQM's for meaningful use that are electronically specified versions of the quality measures that are used in other CMS programs (core measures and value based purchasing). After those measures are electronically specified, field tested and validated, then it would make sense to us to add additional measures as requirements.

Comment on the proposals to develop a list of care team members and create more virtual communication among those providing services to each patient.

It depends on how this objective is defined in practice. Recording care team members isn't difficult, but how the virtual communication is created may be challenging.

We subscribe to the vision that patients are the most efficient and appropriate keepers of their longitudinal medical record. In our current environment, this medical record can be maintained through the use of a personal health record used to collect and combine health information from multiple sources and settings.

HIE's are often discussed as meeting this requirement, but there seems to still be a semantic disconnect when people discuss an HIE and the future vision for the use of HIE's throughout a region or interconnected across the nation. On one side, discussion seems to indicate that all data from all sources will be replicated (and reconciled?) in every system where a patient accesses care. On the other extreme, all patient data would be maintained in a single place, as in a single EHR.

In the middle is what we believe to be a more likely reality – where some data is “stored” in a patient centric model and “used” by EHR systems in a standard way and other data is local within the workflow of the specific care setting.

1) Data that could be “stored” in a patient centric model and “used” by EHR systems in a standard way would include allergies, home medication list, past family, medical and social history and problem list. These types of data follow the patient throughout their care. Ideally, these sets of data are updated at various points through multiple care settings. The use and updating of this type of data is becoming more standard as EHR adoption increases.

2) Data that is local within the workflow of a specific care setting would include the medications that are available in a particular hospital pharmacy for use with patients admitted as inpatients. Only those medications can be ordered and there is a process for transmitting that order to the pharmacy, verifying the order, fulfilling the order and administration at the patient bedside. Another example is lab tests. Only specific lab tests are performed at a hospital or clinic lab. In addition to the order for the lab test, there is a process for transmitting that order to a lab, collecting the specimen, conducting the test, verifying the result and transmitting it back to the EHR system. Those are currently local activities and would be maintained in a local system with

only the results shared with an HIE or personal health record.

Other Stage 2 concerns

The web portal requirement description indicates that hospitals will send “all information” about a patient’s hospital stay. In our experience, patients do not want “all information” about their stay. To receive all vital signs taken during a three-day stay in the hospital would be overwhelming and would not be helpful in understanding their care needs. We’d encourage CMS to limit any portal requirements to data known to be requested and desired by patients and reasonable to provide in a format that patients can use.

CPOE. We hope there will be a change in this measure to be a percent of orders entered using CPOE. This would be clear and simple. For sites not entering all orders into the system by any means, this would move them toward adoption so they could report on the percentage.

In our experience with measuring the use and effectiveness of EHR adoption at our local sites, the clearer and simpler the measures – the more effective they are in driving adoption and effective use of the system.

Measure concepts that ONC and CMS are encouraging for Stage 3

These measures look valuable on the surface, but almost none of them are commonly collected or utilized in our system. If these are clinical quality measures that are electronically specified, field tested, validated and endorsed – we are unaware of them.

Quality measures that require data to be assembled across multiple settings or over time – such as patient-reported measures, delta measures, those that require linkages between clinical and claims data.

As described above, we envision a future where there is a hybrid model of patient data sharing and storage. In this model some data is maintained “centrally” and by the patient and other data is maintained and utilized locally.

We believe that patients are the most efficient and appropriate keepers of their longitudinal medical record across multiple sources and settings.

Patient reactions

Our patients are unaware of meaningful use.

How Meaningful Use has affected our organization's other strategic initiatives

We are apprehensive about the effort to achieve Stage 2 of meaningful use while also implementing ICD-10. Both requirements are extensive and will necessitate significant resources.