

**Testimony to the ONC Policy Committee --Meaningful Use Workgroup
Panel 2: Providers: Working Toward Meaningful Use Stage 3**

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Dr. Tang, Mr. Hripcsak, and members of the Meaningful Use Workgroup:

My name is Dr. Carol Steltenkamp. Thank you for the opportunity to address this group. I am here representing the experience of my organization, the University of Kentucky. UK is a traditional academic medical center that is housed within the land grant university of the Commonwealth of Kentucky. I also have the privilege of directing the Kentucky Regional Extension Center. The comments below reflect this cumulative experience and as such I appreciate the collaborative efforts of my colleagues and staff at these organizations.

What is the experience of EPs and EHs in implementing meaningful use in the field, and how can that inform meaningful use in Stages 2 and 3?

Experience with Meaningful Use:

- *Do you plan to apply for reimbursement for Meaningful Use of HIT via Medicare or Medicaid?*

UK Chandler Hospital, KY Children's Hospital and Good Samaritan Hospitals apply under a single provider number. The organization was the first hospital in the country to receive Medicaid funds (January 5, 2011). We will be applying for Medicare funds in the second quarter of 2012.

The eligible providers associated with our academic medical center will be applying in a phased fashion throughout 2012.

The Kentucky Regional Extension Center is at 90% for its M1 goal and at 20% for its M2 benchmark.

- *When do you plan to begin your Meaningful Use reporting period?*

UK HealthCare Hospitals will begin our Meaningful Use reporting period in the second quarter of 2012. Some of the eligible providers will begin their reporting period in March 2012.

The clientele of the KY REC appreciate the time sensitive nature of attesting to Medicare and/or Medicaid incentives but many are in 'limbo', awaiting action from their vendor to move to a certified version of their adopted software.

- *Which objective requirements do you find easy to meet (or exceed)?*

Those core objectives that use information technology to standardize work processes across the entire health care enterprise are most easily met.

Those include, but are not limited to:

CPOE for all orders

Drug-drug, drug-allergy, and drug-formulary checks

Record demographics (Language, DOB, race, ethnicity, insurance, gender, cause of death)

Maintain active medication list.

Maintain active medication allergy list.
Record and chart changes in vital signs (Includes BMI & Growth Charts)
Record smoking status for patients 13 years old or older.
Implement one clinical decision support rule associated with high-priority hospital condition)

The electronic exchange of information has proven to be quite successful in the Commonwealth as the statewide HIE is operational and the cost for interface is only that which is charged by the office vendor. The HIE has no charge at this time.

- *Which core objectives have posed the greatest challenges to you meeting the requirements (and why)?*

Maintenance of an up-to-date problem list can be automated by pulling such things as 'reason for visit' and various fields from structured nursing documentation. Though this may meet the requirements for attestation, it does not optimize the use of the problem list. Problem list maintenance has not been a regular part of the physician workflow so its current breadth and depth may be found lacking. At UK HealthCare we are enriching the physician documentation to facilitate the movement of valuable, timely information to the problem list.

Cost of printing out a copy of the visit summaries in some rural clinics (because the patients don't have electronic access) has been an identified challenge which is compounded by the fact that the patients will then often throw away the paper before ever making it to their vehicle.

Many providers have not yet identified challenges because of vendor delays as noted above. This has also obviously hampered the exchange of information.

We do support a transgender population and there is no way to account for this within the demographic specifications.

An anecdote of note: One of our rural implementation specialists received a call from a patient. The patient was given the number by a flustered desk clerk at a small multispecialty group in Eastern KY. The patient was livid that they would be asked their race and ethnicity and it was 'mandated' by a federal program.

- *Which menu objectives have posed the greatest challenges to you meeting the requirements (and why)?*

The capability to submit electronic data to immunization registries can be cost prohibitive. Although the Commonwealth of KY is rolling out their electronic immunization registry at no cost, the vendors charge for the construction of an interface.

The same argument can be made regarding electronic surveillance data. On that note, UK HealthCare had an existing interface from our lab system to the appropriate state database. The lab application is not our 'certified' software application for attestation. This means that a new interface must be built, a replication of effort.

Some clients of the REC have been lead to an information exchange that is vendor specific amongst the users of particular software. While this meets the requirements for information exchange, it is not conducive to unobstructed movement of patient data.

- *How well have the Meaningful Use clinical quality measures aligned with other measures in common use in your field? How easy or difficult has it been to report them for this program?*

Initial challenges centered on defining the terms including the 'numerators' and the 'denominators'.

Ideally, the quality measures of this program would align with the measurements of other initiatives. Practitioners want to provide the highest quality of care but extracting the information necessary to document that provision remains a challenge. To that end, most users have chosen to report on clinical quality measures that are part of their current workflow. Our experience at UK HealthCare supports this notion.

- *Has the EHR certification program made it easier for you to report on the meaningful use quality measures?*

The REC has experienced some challenges in this realm. Specifically, some customers have applications that have only been certified on a finite number of quality measures. These quality measures may not be the ones most appropriate for that provider---thus a disconnect with the needs of the practice.

At our own organization, we have worked with our vendor to map to the specific data fields, allowing for accurate reporting. This will require constant monitoring of the configuration so as not to disturb that reporting relationship.

- *What have been the major challenges, especially external factors (links to other organizations, vendor issues, etc.)?*

Vendor issues have been a **major** impediment. Some vendors are unable to get to practices within an appropriate time to allow for attestation and application. Charges for interfaces can be exorbitant. In Kentucky, the REC's and the Kentucky HIE are working together to address vendor concerns, but this is bigger than a state issue.

The Critical Access Hospitals and Rural Hospitals and Clinics can be both financially and temporally challenged to meet meaningful use if they began their EHR trek with the announcement of this program. Although provisions have been made to aid in purchase of systems, the upfront costs can be daunting, oftentimes requiring loans for acquisition. The workforce development initiative is underway but it began at the same time as the meaningful use program which established a time lag between the immediate need for assistance at the office level and the availability of a trained workforce. This is can be particularly acute in rural areas.

Adoption of an electronic health record is unquestionable the right thing to do. Changing how a clinician practices remains a challenge.

- *What do you estimate is your project cost to implement meaningful use?*

The REC has estimated that our clients spend an average of \$30,000 per provider for implementation with approximately 20% of their original cost as an annual maintenance fee.

Because UK HealthCare was already well down the implementation path, the cost of focusing on meaningful use is estimated to be the equivalent of 1.5 FTE for our organization.

- *Looking at proposed Stage 2 objectives, please comment on the proposals to develop a list of “care team” members and create more virtual communication among those providing services to each patient.*

Automated generation of the care team list from encounters, bills, etc, may be useful so that it is apparent who has cared for this patient. Any requirement for a busy clinician to perform data entry will fail. The automation could lead to a lengthy out of date list so maintenance of an accurate listing would be necessary--leading to the similar challenges noted previously regarding the problem list. The concept is ideal to support the medical home but the execution and maintenance will require effort.

Acknowledgement of the differences in the care team membership across settings of care is mandatory. For instance, the third shift CMA on day 21 of a prolonged hospital stay does not play as an important ongoing role as the Primary Care provider does on a daily basis.

The patient has a role in this communication loop and should be included at the outset.

- *Looking at the proposed framework for Stage 2 quality measurement, and the “measure concepts” that ONC and CMS are encouraging for Stage 3, how do you assess the value of those measures to your organization, and the ease/difficulty of collecting and reporting them?*

Those efforts that build on previous quality measures by requiring maximum ‘individual’ (internal to your practice, group, or health system) performance will be acceptable and achievable. These build on the desire for continuing quality improvement.

The quality measures related to patient and family engagement will likely present a challenge for both the caregivers and the patients. The enactment of this via asynchronous electronic communication is not a common workflow for most providers. Thus, it presents a potential significant change in practice patterns. And the measurement of the effectiveness is unsure.

Incorporation of multiple care plans across multiple platforms is and will likely continue to be problematic as we approach Stage 3 of meaningful use. The role and boundaries of each provider may be difficult to discern. The actual technology to identify the ‘single source of truth’ will likely be easier to decipher than the responsibilities of the individual care providers.

- *Please comment on the value of introducing quality measures that require data to be assembled across multiple settings or over time – such as patient-reported measures, delta measures that compare an*

indicator at time one vs time two, or those that require linkages between clinical and claims data. For such measures, please comment on your interest in HIEs, registries, or other data integration partners.

The Kentucky HIE is actively exchanging data and UK HealthCare is a participant. To date that participation has been for the benefit of patient care not for quality measurement. The same can be said for the majority of the KHIE participants. However, we do participate in the University Health Consortium (UHC) comparative analysis activities. Internally, we use commercially purchased software to run quality comparative reports against our clinical database.

Leveraging quality measurements across organizations and care encounters is fraught with great challenge---both human and technical.

- *How have your patients reacted to your efforts to qualify for meaningful use; have they used the functions designed to increase patient engagement?*

Most patients are not aware of the meaningful use concept.

The patient experience of their clinicians' use of an electronic medical record has been very positive. The patient response to portal technology has been generally positive with use correlating their overall computer use.

- *What objectives in MU Stage 3 would help you achieve the goals of accountable care?*

Using a patient encounter as a 'template' the following our suggested for consideration:

- Patient identifier
- Identification of necessary, measurable data associated with specific chronic disease states
- Standardization of discrete patient data that is transferable across care settings

Again, the request to align reporting measures to an appropriate level of detail.

- How has your work on Meaningful Use affected your organization's other strategic initiatives? Has it caused you to postpone other strategic initiatives? If so, which initiatives were postponed and how does your organization judge the relative merits of the tradeoffs caused by the shift in priorities?

UK HealthCare has been moving in the direction of an Enterprise-wide patient-centered electronic medical record for many years so the concept was not disruptive. The goals established for meaningful use are worthy and attainable which appeals to caregivers. However, the need to adjust our activities to meet the reporting requirements has caused some frustration for those users whose needs have been circumvented.

From the REC perspective, I would like to share what one provider told me:

“Doing this is the right thing to do but we all know that doing the right thing isn’t always easy.”