

Stage 1 Meaningful Use Testimony by Protima Advani, The Advisory Board Company

In my role as a Research Director at the Advisory Board Company, I work with hospital and health system CIOs and IT executives, specifically around their efforts to demonstrate meaningful use (MU)—answering their specific questions about the various requirements and the MU program, helping assess their readiness, guiding their MU plans to ensure success for the long haul, etc. The responses to the questions below reflect my work with over 150 institutions that are members of our IT research and advisory services at the Advisory Board Company. Please do not hesitate to contact me if I can provide greater detail or be of assistance – I can be reached on my cell 703-868-7274 or via email at advanip@advisory.com

Panel 2: Working Towards Meaningful Use

- 1. Which objective requirements do you find easy to meet (or exceed)?**
- 2. Which core objectives have posed the greatest challenges to you meeting the requirements (and why)?**
- 3. Which menu objectives have posed the greatest challenges to you meeting the requirements (and why)?**

Requirements that leverage existing hospital workflows and do not require configuration of systems to a new set of specifications have been easiest for hospitals to meet. For example: documenting vital signs (core) or advance directives (menu) is easy and part of the workflow at most hospitals. Similarly, enabling drug-drug/drug-allergy (core) and drug-formulary (menu) checks is easy for most hospitals to comply with since many of them already had these capabilities in use.

In contrast, objectives that have nuanced specifications or fundamentally change the hospital's existing practices have been more challenging to achieve. For example: while most hospitals document patient demographics (core) and smoking status (core), having to reconfigure their systems and train staff to document race and ethnicity using OMB standards and smoking status using CDC recodes has delayed their readiness on these requirements. Similarly, providing patients with an electronic copy of health information (core) in CCD/CCR format is not common practice – most hospitals have a process in place for providing patients with a copy of their legal medical record in human readable format, but not as a CCD/CCR with coded problem lists, medication lists, etc. and hence providers are struggling to meet this MU requirement. Other requirements reliant on the CCD/CCR, such as performing the test of exchange of key clinical information (core) or providing a summary of care record (menu) have also been challenging because they rely on a new capability that most hospitals haven't adopted to date. In fact, for most hospitals, purchasing the CCD/CCR capability was an added expense and not part of their existing EHR contract with their vendor.

Documenting the problem list (core) in ICD-9 or SNOMED has also proven to be particularly difficult for most organizations. Specifically, the challenge lies in driving clinicians (specifically physicians) to document a problem and determining a way to code that problem in the required standard in a timely manner. At most hospitals, documenting patient's complaints has been part of the admissions assessment, not necessarily as structured data and with no significant reliance on the data. However under MU, the problem list must be coded and subsequently populate other requirements like the e-copy of health information (core) in a timely manner. I have seen 2 primary problems with this core requirement as structured – first, the problem list isn't really indicative of the final diagnosis and hence has little downstream value for billing or information sharing purposes. Yet, to be compliant with meaningful use, hospitals are forced to either purchase software that can map common medical vocabulary (entered by the clinician) to ICD-9 or SNOMED or to invest in coders to code the data manually concurrently or upon patient discharge. Second, the coded problem list is a root capability for other requirements like providing patients with e-copies of health information (core) within 3 business days upon request or providing a summary of care record (menu). With the e-copy of health information (core) due within 3 business days upon request, providers reliant on coders to code problem lists upon patient discharge are now forced to expedite the coding process to support timely provision of the e-copy, if requested. As a result, providers continue to struggle with meeting the problem list requirement and other requirements dependent on it.

Finally, clinical quality measures are probably the most challenging core requirement (discussed as part of question 4 below). On the menu side, most providers struggle with providing a summary of care record (as discussed above), medication reconciliation and the population and public health requirements (reasons discussed in question 6 below). Absent house-wide adoption of CPOE (majority of hospitals are still in the process of implementing CPOE), physicians lack the necessary information electronically to perform medication reconciliation. As a result at many institutions, electronic medication reconciliation is a menu item that has been deferred to Stage 2 and in the interim the process continues to be paper-based one.

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

Reporting on clinical quality measures (CQMs) is the most resource intensive and challenging requirement for hospitals. For starters, most organizations are not aware of the specification sheets surrounding each CQM and assumed that if they were already reporting on Stroke measures for another program, they could use the same data, calculation, and reports for MU reporting. Unfortunately, the CQMs for MU do not align with other quality

reporting programs that hospitals participate in. Secondly, to date, most hospitals have relied on vendors like Midas, etc. to do quality measure reporting for them and to that end, have staff responsible for abstracting data from patient charts into a spreadsheet for the reporting vendor.

CQM reporting for MU is a paradigm shift – it demands volumes of additional data: one analysis done by CSC suggests that electronic documentation for the core and menu requirements would only generate 35% of the data needed for CQM reporting; in essence hospitals still need to capture 65% of the data for CQM reporting outside the core and menu requirements. Furthermore, because hospitals need to generate the CQM report based on data in the certified EHR and using a certified reporting module, they can no longer rely on chart abstractions but rather need to ensure all the data is available electronically. To successfully report on these measures (even though there are no performance thresholds for the CQMs), hospitals will be forced to invest significant resources to evaluate CQM specifications, identify gaps in data availability, and subsequently configure systems, redesign processes and train clinicians to capture all the data electronically. Yet, despite all this effort, it is unlikely that these measures will be complete and accurate to drive any improvements – why? because objectives such as medication reconciliation are menu items and absent compliance with this requirement, several key data points are not captured electronically, resulting in zeros during CQM calculations.

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

Certification is well intended but has several issues that need resolved in future stages. First, as is well known, certification doesn't guarantee usability or ease in achieving the MU requirements. Several organizations continue to struggle in adopting the certified capabilities necessary for MU requirements, especially when relying on their EHRs for non-clinical uses (not the core competency of most EHR vendors) such as providing patients with e-copies of health information or discharge instructions, generating CQM reports, leveraging the EHR to suggest patient-specific educational resources etc.

Second, certified products do not necessarily include the MU specifications, leaving it to providers to further configure systems to capture data as required for MU; for example: most certified EHRs do not include the CDC recodes for smoking status even though it is the required MU standard, leaving it to the provider to further configure the certified system for MU compliance. This could be an easy fix in future certification requirements and would reduce the burden on providers and ensure their compliance with MU specifications.

Third, certification has resulted in purchase of redundant or unnecessary modules since providers must possess the full suite of certified MU capabilities, not just the ones they

intend to report on. As a result, providers have been forced to acquire additional capabilities from their primary EHR vendors to secure certification for attestation, even though many of these capabilities would be better purchased from niche vendors. If we want to promote innovation and usability, we need to get away from certifying the complete EHR but rather push for modular certification of interoperable products so that providers can assemble the best suite of products that meets their needs without being hostage to acquiring everything from a single vendor in the name of certification.

And finally, while the CHPL website is designed to generate the CMS Certification ID Number for each provider who intends to attest, the website is not bullet proof or detailed enough. As a result, several providers have secured a certification number without accurately declaring the suite of products they intend to use for MU. Providers would be better served with a questionnaire that asked them to list the exact product used for each requirement and all the products they possess via contract from their vendors so that they could generate an accurate and meaningful certification number.

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

Population and public health requirements have been particularly challenging for most providers for a few reasons – if organizations were already reporting to their State’s health department, the need to use certified capabilities added to expense and change in process, without any tangible benefit to the organization. Alternatively, if organizations haven’t previously participated in such population level reporting, they lacked a State level resource to help them identify which public health agencies would be candidates for such testing and submission. Finally, in many states, the public health agencies just aren’t ready to test such data submission capabilities and without a central resource that declares this lack of readiness publically, providers are unsure about the extent of searching they must do for a test partner before taking the exclusion. California has very good guidance on which agency each provider should test with based on their region and type of test they want to conduct – this kind of information would be helpful to have at the State level so that providers can identify test partners and in the event there is no viable test partner, secure the necessary documentation to prove that for exclusion and audit purposes. Furthermore, such State level resources could provide links to these public health agencies and their specifications around data/standards/formats etc. required for testing and information on testing dates in the case of a backlog.

Overall Observations and Suggestions for Framing Stage 3 Requirements:

The Meaningful Use (MU) program has definitely accelerated the pace of EHR adoption at hospitals and health systems across the country – irrespective of size or type of facility: big or

small, community or academic medical center. That said, for many, MU is viewed as a federal mandate—CFOs and CEOs are pushing CIOs to get to MU and collect the incentives, failing to recognize the voluntary nature of this program and its ultimate intent of driving to a higher level of IT adoption. As a result, MU has become a compliance effort at many institutions, with providers aiming for the lowest bar, finding workarounds and loopholes to meet requirements and collect incentives. For example: many institutions that attested to MU did not have a single patient request electronic copies of their health information or discharge instructions, allowing the institution to easily meet those requirements even though they will be prompt in telling you that they are not confident that they would meet those requirements if patients did ask for the same on a regular basis – patient ignorance around their rights has proved to be an easy win for several hospitals with regards to demonstrating certain MU requirements. This doesn't bode well for us as an industry where capabilities exist but are not being adopted optimally to realize the benefits of electronic data capture and exchange capabilities.

In general, a deeper understanding of the meaningful use requirements and their intent is missing for most organizations, raising larger concerns about their ability to meet future, more complex requirements. All efforts to clarify expectations around future MU requirements (as part of the rule making process or shortly thereafter) will help in focusing product design, implementation, and end user adoption to achieve the broader goals of this program. To that end, Stage 3 requirements should be less about adopting new and more advanced capabilities but rather focus on outcomes. This will be a win-win for all – providers will be forced to leverage their EHRs to achieve tangible goals, vendors will need to focus on product usability to support effective and efficient goal achievement (leading to a better, more widely accepted technology solution among the provider community), and the patient and the industry as a whole will benefit from advancements in EHR adoption and information exchange. For example: a Stage 3 requirement around reducing readmission rates by 10% over the previous year will allow each provider to demonstrate progress irrespective of their starting point, while driving innovations in vendor solutions to support providers in achieving this goal through technology adoption and process redesign. And ultimately, such outcome-oriented requirements can help solve for the cost and quality conundrum facing the healthcare industry – driving greater accountability for the value of every dollar spent on health care.

Thank you for allowing me to share my thoughts based on the experiences of the hospitals and health systems I work with. Again, if I can be of any assistance or answer any additional questions, please do not hesitate to contact me: advanip@advisory.com; 703-868-7274.