

# HIT Policy Committee – Meaningful Use Workgroup

October 5, 2011  
Stage 3 Meaningful Use Objectives  
Washington, DC

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Good afternoon. My name is Sasha TerMaat. At Epic, I have helped our customers understand the requirements of Meaningful Use since ARRA was enacted. Over the past few years, I've worked with hundreds of representatives from organizations using our software on everything from participating in the policy-making process to using our certified software for reporting on Meaningful Use. This summer, I've been excited to celebrate with representatives from over 30 organizations using Epic as they've attested to their meaningful use of an EHR. These organizations provide care for approximately 20 million patients. I appreciate this opportunity to share some of the lessons they have learned while implementing Meaningful Use Stage 1, and I'm glad that this experience will inform Meaningful Use Stage 2 and 3.

In addition to my work at Epic, I serve as the Chair of the Electronic Health Records Association Meaningful Use Workgroup. I work with representatives from other software development companies on Meaningful Use education and advocacy. In preparing for today's testimony, I worked with the EHRA Meaningful Use Workgroup, and my testimony reflects the perspective of a larger vendor community.

You asked about which core and menu objectives have posed the greatest challenges in Stage 1, and why.

## Challenges with Quality Measures in Stage 1

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By far the most challenging piece, from both a development and implementation perspective, is the core objective to report quality measures to CMS. There are several factors which contributed to the difficulty of this objective and which lead me to make several suggestions on how to more efficiently introduce quality measures for reporting in future stages of Meaningful Use.

Some of the factors contributing to the difficulty of this objective:

1. The volume of quality measures was greater than the combined volume of other objectives. There are a total of 59 quality measures requiring reports, almost double the 30 objective measures requiring reports.

Here is a more detailed breakdown of the numbers:

There are 25 eligible professional objectives (including both core and menu) and 24 eligible hospital objectives (including both core and menu). EPs and EHs have the opportunity to select 5 menu objectives to report on from a set of 10 objectives, but they are required to possess functionality capable of meeting all of the objectives. Vendors are pressured to support the entire set of menu objectives. Of the 49 core and menu objectives for EPs and EHs, 16 EP measures require reporting a percent threshold and 14 hospital measures require reporting a percent threshold, for a total of 30 reports.

There are 44 eligible professional quality measures and 15 hospital quality measures, for a total of 59 reports. Again, individual providers are given some flexibility in selecting only 6 quality measures to report on, but vendors must support at least 9 to achieve certification. Additionally, the CMS requirement that providers must report on quality measures with non-zero denominators means that many healthcare organizations must implement all 44 EP measures to adequately support providers of various specialties and patient populations.

2. There is sometimes a misconception that introducing a new quality measure only involves programming a new calculation into the EHR to generate a numerator and denominator. In the experience of the EHR development community, that is only a small portion of the work of adding support for a new measure. The majority of the work results from new implied documentation requirements to capture all the data that is necessary to perform that calculation.

In Stage 1, quality measure specifications introduced many workflow data capture requirements not otherwise required by Meaningful Use objectives. A few examples of data required for accurate quality measures calculation but not required for other objectives:

- procedures and surgical history (including some outpatient measures which require information about inpatient procedures),
- patient counseling
- follow up plans
- discrete documentation of symptoms (for example, asthma frequency)
- cancer staging
- discrete documentation of communications (such as providers sending results to one another)

- discrete documentation of exclusion from a quality measure for medical, patient, or system reasons, or for other reasons such as terminal illness

Some quality measures introduced in Stage 1 make use of the discrete data captured as part of other Meaningful Use objectives, whereas others have posed significant challenges due to additional data capture requirements. Here are two examples from the EP core set in Stage 1.

**First example:**

NQF 0013 – Blood pressure management

This quality measure evaluates data elements (blood pressure, hypertension diagnoses) discretely captured within the EHR as part of other Meaningful Use objectives (updating the problem list, capturing vitals). There is not additional data capture work added to a clinician's workflow to capture, summarize, or attest the information necessary for this measure.

**Second example:**

NQF 0421 – Adult weight screening and follow up

Some of the data elements in this measure (height, weight) are discretely captured within the EHR as part of other Meaningful Use documentation requirements. But other data elements are not, including:

- excluding the patient due to a terminal illness
- excluding the patient due to a medical, patient, or system reason
- referring the patient for a dietary consultation
- documenting a discrete BMI follow-up plan
- documentation of a performed gastric bypass

All of these data elements might require new documentation tools for discrete capture and might introduce new workflows for clinicians. This additional data capture means that a single quality measure might be a project for developers requiring multiple new tools for documentation (as well as computing the results of the measure) and a project for providers to implement and begin using the new tools in their practice.

See # 2 in the next section for my recommendation on this issue.

3. Specifications include errors or ambiguity which cause confusion during development and implementation. The process to have errors corrected and ambiguity resolved was initially confusing and remains slow.

These challenges lead EHR developers to make the following recommendations for the measure concepts proposed for Stage 2 and 3.

#### Stage 2 and 3 Quality Measure Recommendations

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1. Fewer measures. Narrow the list to a smaller set of proposed measures and concepts. Focusing on a smaller set of measures allows more time for development of appropriate tools, implementation of appropriate tools, and results in better clinician experience and perception of quality reporting. Better tools also results in more accurate data.
2. Choose measures that can be reported using EHR data required by other Meaningful Use objectives. This requirement will capitalize of the focus already given to Meaningful Use data capture, rather than diverting effort to measures that are unlikely to produce good data in the short term.
3. Ensure that high quality specifications are available for efficient programming and implementation of new data capture workflows.
  - a. Some of the measure concepts are still without specifications. EHR developers are concerned that these measures are not realistic to include in Stage 2 and that work must move quickly for them to be included in Stage 3.
  - b. Test measures for errors prior to publishing final specifications for certification.
  - c. Implement a process for efficient resolution of issues with measure specifications (Who is responsible? Is it with CMS? The measure developer? What is a reasonable turnaround time to expect with a problem with measure specifications?).
4. To expand the set of quality measures within EHRs, continue and accelerate work to align quality measures and reporting mechanisms across different programs. When developers and providers must program and implement two reports for different specifications of the same measure (for example, between Core Measures and Meaningful Use EH quality measures), then they have less capacity to introduce additional measures. One of your questions asked about EHR features to support accountable care – aligning the measure specifications required for reporting on accountable care with those required for reporting on

Meaningful Use is important to avoid wasted effort reporting on similar but not identical measures in different programs.

## Stage 2 Development Estimates

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To conclude my response to the first set of questions, you asked how long it will take to develop and implement the proposed Stage 2 objectives. Generally, EHR developers feel it is not possible to estimate this accurately without specifications for reporting (because reporting specifications might have implications on data capture or system auditing), data standards, implementation guides, and certification criteria and test scripts.

When presented with a similar level of detail on Meaningful Use objectives in Stage 1, Epic estimated that our software was very ready for Meaningful Use reporting. The specific details in the specifications, the requirements in the certification criteria, the standards chosen, and the ongoing changes required to keep up with CMS and ONC clarifications, have resulted in a very large investment of development time that was not anticipated when we had only high-level proposals of objectives. Detailed information is key to making accurate estimates.

## Deployment Models

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You asked about how customers are implementing their systems, for example via ASPs or local installs. In talking with the vendor community, we have not noticed any significant changes to these patterns in the last few years. Across models, we are seeing the same patterns of work in regards to Meaningful Use, as the process of programming new tools for data capture and introducing those tools to users are similar.

## Health Information Exchange

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You inquired about health information exchange. Both Epic and the EHRA have been strong proponents of interoperability standards and demonstrations. However, recent HIE efforts, such as grants to state-designated entities, do not seem to be generating exchange between providers and do not always appear to have sustainable foundations. We're concerned that the money distributed to these organizations is not tied to adherence to a single federal standard. We also suggest that these HIEs be required to offer test platforms for providers seeking to achieve Stage 1 Meaningful Use objectives. For example, NIST provided an automated mechanism for vendors to test the CCD that their software generated prior to certification. State HIEs should be required to maintain a similar mechanism which would allow providers to perform a test that meets the objective, and also accelerate the participation of providers with exchange.

## Sharing Data with Patients

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I have worked on Meaningful Use with many sites that provide information to their patients via a patient portal, allow their patients to interact with the health system online, and provide information to their patients in interoperable downloads. They have found success sharing data with their patients, but have also identified some challenge areas. My discussions with other EHR vendors have shown that these are not unique challenges. Here are areas where they have concerns:

1. Providing sensitive information to patients, such as information about mental health conditions or information about minors to their parents. This can be especially challenging if a provider practices in a state with unique requirements.
2. Requirements that information be provided to patients within a narrow timeframe, which might not allow the provider to fully review the information before it is released to patients. Organizations have indicated that the time requirements are not always compatible with their current review practices.
3. Confusion resulting from the discrepancy, in Stage 1, of the certification standards identified by ONC for patient summaries and the larger set of information required to be provided to patients in the CMS Final Rule.
4. Confusion resulting from terminology without a clear definition, such as terms like “diagnostic test results.” Is this all results in the patient’s record? Results from the most recent visit? The most recent results of certain types? It seems that where requirements are vague it is expected that providers will exercise their discretion in determining what is appropriate, but many are confused about what is expected and if they might face penalties if they exercise what they believe to be reasonable discretion and are later audited.

## Image Capture, Storage, and Review

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The capabilities available for image capture, storage, and review vary greatly depending on the intended workflow. In some cases, these functions are provided by specialized systems (such as PACS or document management systems). Duplicating specialized features of other systems within the EHR would likely not be the best use of resources at this time.

## Postponed Major Initiatives

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In discussing this question with other vendors in the EHRA, there was general agreement that EHR developers have had to postpone work on customer-requested enhancements to their systems in order to focus attention on Meaningful Use certification requirements and customer support.

## Conclusion

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I appreciate your consideration of the experiences of the EHR development community with Stage 1 and our recommendations for making future stages of Meaningful Use as successful as possible.