Health IT Policy Committee

A Public Advisory Body on Health Information Technology to the National Coordinator for Health IT

MU Listening Sessions
May 20, 2014 and May 27, 2014

Paul Tang, chair
George Hripcsak, co-chair

July 8, 2014

Meaningful Use Workgroup Members

Health IT Policy Committee
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* Subgroup Leads

Session Panels and Questions

- **Listening Session 1: May 20, 2014**
  - Panel 1: Eligible professionals
  - Panel 2: Eligible hospitals
- **Listening Session 2: May 27, 2014**
  - Panel 3: HIT Support of Advanced Models of Care
  - Panel 4: Vendors

Overall Findings (I)

- MU1 useful and not unduly burdensome; MU2 has been challenging
- Scope and pace of change causes vendors and providers to focus on meeting the letter of MU and less on the spirit of MU
  - Sometimes burden of documenting compliance (certification or MU measure) exceeds effort of implementing functionality
  - Fear, due to audits, is often a factor in driving implementations
- Transition of care (ToC) is the most challenging
  - Requirements of effective ToC not well defined; wasn't happening in paper world
  - Requires new workflow that takes time to implement efficiently and well
  - Difficult to identify electronic recipients ready to accept (synchronous with readiness to transmit)
  - Need to exchange more useful information, not just more data
  - Direct not working well
- Proprietary business interests and legacy technologies are impeding exchange
  - Prioritize information exchange for care coordination and patient engagement
  - Key to exchange is in the local community
  - Need policies for exchange across state boundaries and patient matching

Overall Findings (II)

- Timelines are unaligned or misaligned (programs, EP vs EH, CQMs, standards)
- Timing
  - Late delivery of final rules and guidance has impeded delivery of certified products
  - Providers and vendors are overwhelmed by the current pace and scope
  - Need more time to prepare for stage 3 and learn from stage 2 (though one vendor expressed the need to keep moving forward and not slow down)
- Multiple patient portals fragments records and workflows for patients
- Patients believe that EHRs are useful across the range of clinical and patient-facing functions. However, patients' ability to understand fully and benefit from the information may be affected by health literacy
- Challenges with measures outside of provider's control (e.g., secure messaging)
- Certification process overly rigid and complex, and impacts usability
  - Lack of quality, unambiguous specifications make interpretation variable, resulting in rework and usability issues
- Redundant reporting requirements (CQMs)
- Panelists "thrilled" to be able to share experiences to help others

Suggestions for Improvement (I)

- Focus on challenges only government can solve
  - Interoperability infrastructure ('the highway')
    - Pick standards
    - Require exchange (pull through payment or accreditation)
    - Avoid penalizing early adopters (who depend on recipients being ready)
  - Policy interoperability (governance) – 'rules of the road'
  - Essential HIT functionality ('the cars')
    - Ensure functionality available (certification)
    - Require implementation, esp in support of care coordination
    - But leave details flexible (min number, not percentage threshold) to accommodate diversity of specialties and locations
- Focus on what, not how
  - Functional certification – 'what' functions to include
    - Fix what is not working as intended (e.g., Direct)
  - Make results of certification transparent so the market can assess the quality of 'how' – make the 'how' competitive

Suggestions for Improvement (II)

- Emphasize CQMs that measure outcomes that matter to patients
- Create coordinated, aligned end-to-end certification process
  - Avoid being overly prescriptive to allow more innovation and greater focus on usability
  - Reduce complexity and burden of compliance documentation (certification and MU)
- Provide the required 18 month timeline and align it among program participants.
- Align timelines across all government programs
- Provide national database of public health agencies ready to receive reports
- Need public feedback mechanisms with clear, authoritative FAQ answers and rapid turnaround time

Appendix: Listening Session Panel Details

Session Panels and Questions

- **Listening Session 1: May 20, 2014**
  - Panel 1: Eligible professionals
  - Panel 2: Eligible hospitals
- **Listening Session 2: May 27, 2014**
  - Panel 3: HIT Support of Advanced Models of Care
  - Panel 4: Vendors
- **Panel questions**
  - What were the key challenges and success factors in your experience with meeting the requirements of Stage 2?
  - What advice would you give to the HIT Policy Committee, based on your experience with Stages 1 and 2, to inform recommendations for Stage 3?
  - What benefits have you realized in your organization as a result of implementing an EHR and meeting the requirements of Stages 1 and 2?

Panel 1: Eligible Professionals

- Doug Ashinsky, Warren Internal Medicine
- Michael Lee, Atrius Health
- Harris Stutman, MemorialCare Health System
- Eugene Heslin, Bridge Street Family Medicine
- Dawn Sullivan, patient

Summary
Panel 1: Eligible Professionals

- Meaningful Use Experience
  - MU stage 1 uniformly was useful and not unduly burdensome
  - MU stage 2 was challenging for everyone, especially
    - Transition of Care (ToC)
      - ToC is not well defined; was not there on paper
      - Issues with referral sources and new workflows are required
      - Recipients not ready or are overwhelmed (e.g., too much data defeats the purpose)
      - Infrastructure with Direct and HISP is not necessarily available
        - » Sometimes requiring Direct is a step backwards from current
      - Should not require % electronic, since no control over recipient
      - Focus on interoperability, but don't require a threshold.
      - TOC needs to be more flexible in scope and content
    - Measure percentages not necessarily applicable to everyone
      - Secure patient message
      - Patient reminders
  - The certification process is overly rigid/complex and impacts usability
  - Concerns about objectives that are outside the control of physicians (e.g., secure messaging)
  - Redundant reporting requirements (CQMs)

Panel 1 Suggestions

- Suggestions
  - Shift ToC to MU 3
  - Original 2-year cycle too fast
  - Require implementation (demonstrate use), but not specific percentage for everyone
  - Focus on a few things and aim to design objectives and certification criteria to get the right information to the right place
  - Focus on outcomes-based measures, reporting on outcomes that matter to the organization
  - Focus on interoperability, but not %
  - Focus on reporting to registries and public health agencies
  - Timelines need to be aligned with other programs

Panel 2: Eligible Hospitals

- Dan Griess, Box Butte General Hospital
- Stephen Stewart, Henry County Health Center
- Aaron Miri and Pamela Arora, Children's Medical Center
- David Dyer and Barbara Boelter, Somerset Medical Center
- Tom Johnson, DuBois Regional Medical Center

Summary
Panel 2: Eligible Hospitals

- Meaningful Use Experience
  - Vendor implementation issues are impeding stage 2 attestation
  - Some vendors focus on checking off certification criteria without considering provider workflow
  - Timeline for stage 2 is too aggressive
  - Transition of care challenging
    - Lack of recipients for ToC
    - Some markets have no one to receive Direct; some hospitals had to set up Direct mailbox for docs
    - Sometimes had to replace a more functional interface for Direct
    - Some markets not ready to accept CCDs
  - VDT challenging for hospitals
  - Some felt that although TOC and patient engagement were hard, it was worth it
  - CQMs not aligned

Panel 2 Suggestions

- Suggestions
  - Meaningful use is transformative and increases transparency, but standardization for exchange is needed
    - Exchange standards, protocols and workflow need to be more consistent
    - Standards needed to exchange information across state boundaries
  - Need more time to get ready for stage 3
    - Vendors not ready
    - Need time for recipients to get ready for exchange
    - Need time to learn from stage 2
  - Need alignment of CQMs (broadview)
  - Identify a way to share experience and help others
    - A single source for how to interpret objectives is needed
  - A centralized, more rapid turnaround time for FAQs is needed

Panel 3: HIT Support of Advanced Models of Care

- Brian DeVore, Intel
- William O'Byrne and Bala Thirumalainambi, NJHITECH
- Charlie Ishikawa, Joint Public Health Informatics Taskforce
- Mark Savage, National Partnership for Women & Families

Summary
Panel 3: HIT Support of Advanced Models of Care

- Meaningful Use Experience
  - The letter, but not the spirit of meaningful use is being met
  - Vendors and providers view data as proprietary, undermining information exchange
  - Interoperability and the standards continue to be a challenge, as most vendor systems cannot exchange with each other
    - Exchanging across products hasn't been a priority
  - Public health agencies are generally ready and committed, but difficult for provider to know readiness of public health agencies
  - A national database regularly updated by health agencies would ease this challenge
  - Patients' ability to receive and digest information may be affected by health literacy
  - Pass or fail concept is not fair because a provider can fail on one technicality of a single measure
  - Patients overwhelmingly believe that EHRs are useful across the range of clinical and patient-facing functions

Panel 3 Suggestions

- Suggestions
  - Momentum needs to continue
  - Exchange in the local community is most important
  - Additional and more stable funding to support the public health informatics infrastructure will be critical to sustaining public health gains
  - Electronic lab reporting and syndromic surveillance will lead to greater capacities for early disease detection and more real-time population health assessments during public health emergencies
  - Build greater HIT & HIE capabilities for immunizations and reportable conditions
  - Patient portals must accommodate a wide range of literacy and should provide access in preferred language and interoperability with assistive devices

Panel 4: Vendors

- Leigh Burchell, EHRA
- Jonathan Zimmerman, GE Healthcare IT
- Catherine Britton, Siemens
- Dan Haley, athenahealth

Summary
Panel 4: Vendors

- Meaningful Use Experience
  - Tight timing has led to concerns with Stage 2 certified product availability and implementation
    - Need 18 mo. from final rules, specifications, and tools
    - ONC testing tools need to be evaluated prior to execution
    - Implementing measurements is time-consuming
  - Focus more on:
    - Interoperability
    - Care coordination
    - Aligned and fully specified CQMs, more outcomes-oriented
  - The need to measure meaningful use performance has led to design decisions and workflows that exist solely to facilitate semi-automated measurement and not to enhance the value, usefulness, or usability of EHR

Panel 4 Suggestions

- Suggestions
  - Need more time to develop, test, certify
    - 18 mo lead time after all regs, specifications, tools finalized
  - Focus on high priority areas where infrastructure is needed (interoperability for care coordination and CQMs)
  - Policies to facilitate interoperability needed:
    - State regs
    - Patient matching
    - Alignment of CQMs
  - Allow 90-day reporting period for each new stage
  - Need to harmonize and synchronize timelines