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Virtual Hearing of the Health Information Technology Policy Committee

on Experience with Meaningful Use

Tuesday, May 20, 2014 from 10:00 AM- 1:00 PM ET

Testimony of Daniel Griess, FACHE, Chief Executive Officer,

Box Butte General Hospital, Alliance, NE

My name is Daniel Griess, and I am the Chief Executive Officer of Box Butte General Hospital (BBGH), a 25 bed critical access hospital in Alliance, Nebraska. Alliance is located in the center of the Western Nebraska Panhandle and is 155 miles south of Rapid City, South Dakota as well as 250 miles northeast of Denver, Colorado. Our state capital in Lincoln, Nebraska is 400 miles to the east.

Our primary service area includes nearly 12,000 residents in Box Butte County. Additionally, we serve the rural populations located in Sheridan and Grant counties east of Box Butte County. Having an average daily census of 12 patients per day and approximately 5,200 emergency department visits each year, our organization is the second largest hospital within a 140 mile radius. We have three Rural Health Clinics (RHC), one in Alliance, a second in Hemingford, Nebraska, located 19 miles north of Alliance with a population of less than 1,000 residents and a third RHC in Hyannis, Nebraska, located 60 miles to the east of Alliance with a population of less than 300 residents.

I want to thank the members of the Health IT Policy Committee, and the Meaningful Use Work Group for holding this hearing and inviting me to testify. This is a critical time in health care, not only with respect to the adoption of electronic health records (EHRs), but also as we pursue the improvement of care coordination, patient engagement, and quality improvement, while at the same time finding new ways to control health care costs. As requested, I will focus my remarks on three topics:

The key challenges and success factors in our experience with meeting the requirements of Stage 2,
Advice to the policy committee for Stage 3 that stem from our experience, and
The benefits and costs to our hospital and patients from implementing an EHR and pursuing meaningful use.

The Box Butte General Hospital Experience with EHRs and Meaningful Use

In 1994, we partnered with Healthland (formerly known as Dairyland) to replace a "home grown" financial and general ledger software platform. In 2005, we went live with the Electronic Medical Record (EMR) on the hospital side and then in 2012, we went live with the EMR in our physician's clinic. We have been a client with Healthland for 20 years and thus have cultivated a strong relationship. In 2011, we received Healthland's Better Together award recognizing our efforts in making our communities healthier. It was our privilege to be the first Healthland client to receive this award in the inaugural year of 2011. Additionally, we serve as a premier site for Healthland to demonstrate how the platform performs in a live environment to other interested hospitals.

My interest in the advantages of Information Technology began years ago. The Nebraska Information Technology Commission (NITC) created thee-Health Council in February 2007 to facilitate discussions among e-Health initiatives in the state and to make recommendations to the NITC regarding the adoption and interoperability of e-Health technologies. I served as the co-chairperson for the e-Health council beginning in 2007 for two years. Health Information Exchange was a topic central toe-Health and the Nebraska Health Information Initiative (NeHII) was formed. I served on their board of directors throughout NeHII's conception and development. At the same time, a western Nebraska hospital network known as the Rural Nebraska Healthcare Network (RNHN) received a grant from the Agency for Healthcare Research and Quality (AHRQ) to create a Health Information Exchange (HIE) and I was asked to be the CEO representative to lead this effort. These combined efforts were in pursuit of a reduction in healthcare costs, higher quality of care and a reduction in medical errors. Essentially, we in Nebraska were pursuing the triple aim before there was a triple aim.

One thing I learned early in the process, technology vendors, hospitals and patients define readiness quite differently, especially in rural areas. One example of this is as the RNHN evaluated the needs to successfully implement an HIE, we found it necessary to build an information technology workforce using local personnel as well as create minimum standards for the IT platforms across nine hospitals to facilitate exchange. This grass roots effort took quite a bit of time, educational resources and money. As we pursue Meaningful Use criteria throughout the different stages, I find many similarities to the RNHN experience.

BBGH attested and successfully met all of the hospital requirements for Stage I in late August of 2013. I attribute our success to the organizational commitment of the entire staff as well as the leadership of our senior staff and governing board. Due to our early efforts related to our AHRQ experience, we had competent staff who shared a vision to accomplish Stage I Meaningful Use. However, 2014 Stage I has been very difficult due to the limitations of our HIT vendor, Healthland.

We signed a contract in January, 2013 to migrate to Centriq, Healthland's planned 2014 Edition certified solution, with a "go live" date in the fourth quarter of 2013. In the spring of 2013, Healthland notified BBGH that due to the sheer number of migrations, they needed to re-think their organizational strategy and we were placed on hold. Healthland made the decision to certify their Classic version due to the fact they could not meet the aggressive timeline for Meaningful Use attestation with Centriq alone. Additionally , Healthland partnered with a third-party, ICE Technologies, to provide additional task assistance with migrations. BBGH was notified by Healthland of a new timeline -- to begin foundation build in January 2014 with a "go live" date in June 2014. Healthland then decided it would be in our best interest to meet Stage II on the 2014 Edition Classic version instead of migrating to Centriq. BBGH disagreed with this plan due to the fact the Emergency Department, Surgery , Central Scheduling, Bar-Code Med Administration modules are not available on the Classic platform. Following another delay, our team arrived in Minnesota the week of March 1Oth to begin the foundation build in Centriq with a "go live" date of September 22, 2014- more than 9 months after our originally contracted date. When we provided feedback to Healthland the "go live" date was unacceptable and requested them to compress the timeline to meet a "go live" date no later than the middle of August, 2014, they responded with a "go live" date of September 8, 2014.

I have a number of concerns related to the aggressive timeline for Stage II attestation . First, Healthland currently has 400 clients nationwide of which 130 are operating on Centriq. Thirty clients are currently in the migration phase leaving 240 (60%) still operating on the 2011 certified edition of Classic; the 2014 certified Classic solution was scheduled to be released the first quarter of 2014 and then delayed until April 2014 and then again delayed until sometime in May 2014. This version includes hospital functions only; it does not include the physician practice. Therefore , at the time of this written testimony, BBGH does not have a 2014 certified solution from Healthland to use to attest to the 2014 Stage I criteria.

Secondly, BBGH will not begin Stage I 2014 attestation until July 2014, the 4th quarter of the fiscal year leaving no opportunity for failure. Due to the late release in 2014 of the certified solution, BBGH will begin our 90 day 2014 attestation on the 2014 Classic certified platform and will finish on the Centriq platform at the end of September 2014. Finally, we will need to begin Stage II attestation October 2014, shortly after migration to the Centriq platform September 8, 2014. These multiple upgrades and short transitions will create real disruptions to patient care and force a much quicker pace of change than we believe is appropriate.

Even with an above average vendor relationship and being recognized nationally as an early adopter, implementing the Stage 1 meaningful use requirements has become more difficult than we anticipated. And, given the way that the Centers for Medicare and Medicaid Services calculates payments for critical access hospitals as only for a

limited set of capital expenditures, our incentive payments have been very small, and have not covered the bulk of our expenses.

Another difficulty we are realizing is Healthland's patient portal solution has not been released as of this time, and our attestation for 2014 Stage I begins July 2014. A portion of this portal will be used to satisfy 2014 Stage I attestation and shortly thereafter to begin pursuit of our Stage II success.

The last consequence I will mention relates to the Physician Practice module and the inability to pursue meaningful use with the clinic without Centriq. Both the 2011 and 2014 certified Classic solutions do not include the physician's clinic. Therefore, we will not begin attestation for Stage I for the physician's practice until January 2015, after any opportunity to receive positive incentive dollars has passed. The BBGH experience of pursuing of Meaningful Use is typical for America's rural hospitals -- characterized by complexity, limited resources and, often times, less attention from the vendor.

It is quite evident, there are significant benefits to achieving a shared electronic medical record which, in turn, leads to increased patient safety and quality, reductions in duplicate testing leading to lower costs as well as the patient having access to their protected health information to share with specialists and primary care providers for better and safer healthcare. Our facility embraces this technology and we have seen benefits, including an integrated EMR that combines protected health information in the clinic as well as the hospital. Therefore, medical providers seeing patients in the hospital have full access to the necessary information from the clinic record as well as the reverse. This includes medication history, allergies, vital signs, progress notes, and other key information to provide a complete hand-off of information to the primary care and specialty physicians who have been assigned the care of the patient.

And, as our organization looks forward to Stage II, we are cautiously optimistic. We have been building our new Hospital Information System using significant internal resources as well as the expertise and support from Healthland. Of course, with the delays we have experienced, there has been a greater need for accountability and communication. However, to date, our "foundation build" is going ahead.

The complexity of this experience from a rural health perspective is incredibly difficult and poses great risk to our organization. Moving at this pace will cause our organization to transition from the 2011 certified Classic platform to the 2014 certified Classic Platform to the 2014 certified Centriq platform over a three to four month period of time. BBGH employs nearly 300 staff, including physicians and providers, as well as partners with two private practices and nearly 30 specialists who will need to be trained on all three systems. There are times when I believe it would be a better strategy to slow down our pace and potentially pay a penalty than put our patients at risk of a failure due to the complexity in moving at the assigned pace. However, we

understand the importance of the finish line and have committed to lean towards the tape.

Using our Experience to Shape the Future

Rural is different. Limited financial resources and in-house technical expertise make it difficult for rural hospitals to achieve meaningful use within the timeframes that have been set by CMS. Two-thirds of CAHs in this country either have negative or break-even margins. I know of a small CAH 75 miles from Alliance making financial decisions about how to provide heating and cooling for their patients due to an antiquated physical structure, while also striving to meet the meaningful use criteria. As I look further to other Nebraska colleagues, I see a strong commitment to providing the highest quality care to their communities, including the use of EHRs. Progress is being made in adoption of EHRs in rural areas, but the digital divide between urban and rural hospitals persists.

According to data from a June 2013 article in Health Affairs, "large urban hospitals continue to outpace rural and nonteaching hospitals in adopting EHR systems," with 44 percent of all hospitals -- but only one-third of rural hospitals -- having "at least a basic" EHR. (DesRoches, et. al. , Health Affairs 32:8; available at http://content.healthaffairs.org/content/early/2013/06/27/hlthaff.2013.0308.full

The experience of my rural hospital colleagues confirms the academic studies. They are committed to adopting EHRs and using them to improve care. They are making considerable progress, but still have some distance to travel. The high bar in Stage 2 and lack of vendor readiness has me as well as many of the CEOs throughout Nebraska concerned. The small size and geographic isolation of rural hospitals can lead to financial constraints, workforce issues, and difficulties finding and working with vendors that make implementation of electronic health records (EHRs) more challenging for them than for other types of hospitals.

I believe that changes to meaningful use requirements and continued technical assistance are needed to support adoption of EHRs in all communities across the country and ensure that we narrow the digital divide between rural and urban areas. The complexity of meaningful use and the aggressive timelines for the program pose a real challenge for small and rural providers that limit their ability to benefit from the program. The requirements need to be simplified, and the timelines extended for everyone, especially rural hospitals .

Adopt more realistic timelines and more flexible requirements

The continued aggressive timelines for meaningful use could, unfortunately, increase the digital divide. With a mandate for everyone to shift to the 2014 Edition certified EHR at the same time, regardless of stage, my facility has experienced directly the difficulty vendors face to work with all of their customers at the same time. In addition,

the "churn" of replacing systems every year or two - or in our case every few months -- is highly disruptive to clinical staff and works against the program. It also raises concerns about patient safety, although we are committed to implementing EHRs to improve the quality and safety of health care. Finally, meaningful use is not the only federal mandate on health care providers today. We must also prepare for ICD-10, value-based purchasing, medical homes, accountable care organizations, and other initiatives.

Building on 20 years of investment in EHRs, my hospital was proud to be successful in the first year of meaningful use. We will strive mightily to overcome all of the many challenges to being successful in our second and future years . I ask , however, that as you make recommendations to CMS about the future that you really learn from Stage 1 and Stage 2 experience through studies and site visits before locking down new requirements for Stage 3. An analytic approach that does not factor operational realities into account from the beginning may appear to be the solution, but face nearly insurmountable challenges on the ground.

My facility, and others like it, would have a better chance of meeting meaningful use and bringing its benefits to our patients if CMS extended the FY2014 reporting requirements into FY 2015. We are very uncomfortable waiting until the very last reporting period to attest on what will be a brand new system, with no room for any further delays by our vendor, or unanticipated issues in the implementation and use of the upgraded systems. And, given that we are still at Stage 1, we would be muct better positioned if we could use our existing certified EHR -the 2011 Edition --for our second year at Stage 1, rather than taking a mandatory upgrade to the 2014 Edition. It is not a question of commitment or effort. We simply find that vendor capacity and operational realities have put us in a precarious position.

Our experience also shows that the two-year cycle for meaningful use is not realistic, and I believe CMS should extend the length of each stage of meaningful use to be 3 years for all providers. The current two-year cycle is simply too short for vendors to develop safe, useable products that providers can then deploy in safe, efficient ways that really help them better coordinate care, engage patients, and control health care costs. The cultural changes that are needed to fully realize the promise of EHRs requires more time than the current year-over-year changes in meaningful use allow.

Given that we must immediately go to Stage 2 on October 1 of this year and demonstrate meaningful use for the full 2015 fiscal year, we would be more likely to succeed if CMS provided more flexibility in the Stage 2 requirements. The final rules set a very high bar and adopt an "all or nothing" approach, where failure to meet one part of an objective, or missing a threshold by only a small amount means we would not meet meaningful use, and could be subject to payment penalties. We are especially concerned about objectives that make our success contingent on the

capabilities and actions of others- the transitions of care and view, download, and transmit objectives.

I understand that earlier this month CMS reported there are only 4 of the approximately 5,000 hospitals in this country that have successfully attested to the Stage II criteria so far, which further supports my recommendation to re-evaluate the established timelines and complexity of the requirements. I stand ready to assist you and the federal government in learning more about the real-world experience with meaningful use, particularly in rural settings.

Thank you again for the opportunity to participate in today's hearing. I look forward to working with the Committee and all who are committed to the shared goal of widespread adoption of EHRs, whether they live in the largest city or the smallest rural community. Together we can achieve the triple aim of better health, better health care and lower costs for all Americans.