Testimony before the HIT Policy Committee Meaningful Use Workgroup

"Stage 3 of Meaningful Use"

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Introduction

Doctor Tang, Doctor Hripcsak, and members of the workgroup, it is a privilege to be here with you today. I am Jon Zimmerman, Vice President and General Manager of Clinical Business Solutions, the unit of GE Healthcare's IT responsible for our EHR, revenue cycle, and integrated care solutions.

GE Healthcare (GEHC), a unit of General Electric Company, has expertise in medical imaging and information technologies, medical diagnostics, patient monitoring systems, performance improvement, drug discovery, and biopharmaceuticals manufacturing technologies. GEHC's healthcare information technology (HIT) products cover a broad span of clinical, administrative, and financial applications serving customers that range from small physician practices to large integrated delivery networks. We are focused on enabling the evolution of our healthcare system to truly integrated care.

GEHC is passionate about how HIT, including electronic health records (EHRs), can help providers enhance the quality and efficiency of patient care. We are committed to the success of the EHR incentive program and to providing products and services that facilitate truly meaningful use.

I will focus on the first two questions that we have been provided, as these are most relevant to EHR developers: (1) key challenges and success factors in your experience with meeting the requirements of stage 2; and (2) advice to the HIT Policy Committee, based on experience with stages 1 and 2, to inform recommendations for stage 3.

Key Challenges and Success Factors

First, I want to emphasize that the EHR incentive program has helped to drive the substantial increases in EHR adoption that have been documented by such organizations as ONC, CDC, the Commonwealth Foundation, and HIMSS. GE Healthcare has been a supporter of and active participant in the program since its inception. So, we thank you for your leadership here.

Overall, we are now in an increasingly digital ecosystem with substantially increased adoption and use of robust EHRs and the potential for greatly enhanced interoperability. Although adoption rates were increasing prior to the program, it has enabled us to "cross the chasm," moving from earlier adopters to more mainstream use.

At the same time, it is clear from multiple sources, and I can report first hand from our experience and that of our customers, that the program has created challenges for all parties. We appreciate your clear intention to learn from this experience as we design Stage 3. I will outline a few of the most important challenges for our customers and for HIT vendors and associated learnings:

- As confirmed in the CMS/ONC proposed rule on certification released last week, for deep changes of this magnitude, timing has been very tight for vendors and providers. Despite our

collective best efforts, there has been insufficient time between availability of key regulatory and sub-regulatory information and when our customers need our certified EHR technology. This tight timing has, as you know, led to concerns with Stage 2 certified product availability and implementation.

- Meaningful Use is very complex; each measure has detailed specifications and these in turn generate many questions and FAQs, often requiring revised and ever more detailed guidance. This complexity affects vendors and providers and hinders our ability to plan for orderly development and implementation. It also has required substantial diversion of our resources and those of our customers to understanding and communicating about the meaning and intention of specific meaningful use provisions. The complexity of the program expands exponentially with each additional objective and measure.

- A key learning we are finding is that EHR's were not originally implemented in a way that could anticipate future rules. Thus, the first wave of "digitization" created specific workflows and expectations. In many cases, these workflows need to be changed to meet Meaningful Use 2, thus creating a need for a heavier and more prescriptive implementation than was required for Stage 1 and associated certified EHR technology.

- The need to measure meaningful use performance has created provider uncertainty and has, in some cases, led to design decisions and workflows that exist solely to facilitate automated measurement of meaningful use measures and not to enhance the value, usefulness, or usability of EHRs.

- The accelerating use of audits has further complicated the program for our customers and tended to create a focus on provider compliance rather than true "meaningful use" and associated patient and clinician benefits.

- The construction of the program on an "all or nothing" basis, offering providers the stark alternatives of essentially receiving either an "A" or an "F," has further complicated the program and heightened provider anxiety and too great a focus on checking the box.

- There have been many challenges with quality measure reporting, including problems with eMeasures, test tools, variability across government and private sector programs and implementation of standards for electronic submission.

- Vendors and providers have other priorities in addition to meaningful use, including: ICD-10, new payment and delivery models, usability, other healthcare IT systems beyond EHRs, other regulatory requirements, and other desired features/functions. We have experienced first-hand the extent to which incentive program requirements have constrained vendor opportunities to innovate and make other changes requested by customers and, in some cases, limited usability relative to where it might have otherwise been.

Recommendations for Stage 3

So, what do we recommend based on these learnings to date?

First and foremost, we urge CMS and ONC to take a much more focused and prioritized approach to Stage 3 meaningful use objectives and measures and associated certification criteria. This focus should extend the positive trajectory already set out by the Policy Committee in your work to create a more focused approach to Stage 3. Much focus has been achieved but more is needed.

- Fundamentally, and I think consistent with recent recommendations by the Committee's Certification and Adoption Workgroup, the emphasis for Stage 3 should be on greater and more effective use of robust Stage 2 requirements and associated EHR capabilities, and any needed interoperability enhancements.

- A targeted approach, building on the platform established in Stages 1 and 2, will enable providers to get the intended value from the significant capabilities available in 2014 certified versions and enable us to meet the priority needs identified by our customers. It will reduce the extent to which government requirements take precedence over meaningful innovation requested by customers, impose costs and uncertainty, slow certification and implementation, and hinder usability. It will also enable ONC and CMS to meet their policy goals, with their desired high standards for implementation, given the diminished resources available for the incentive program.

- As part of this focus, and recognizing the importance and expanding use of clinical quality measures across multiple federal, state, and private sector programs, we urge CMS to accelerate its efforts, via a public-private partnership to align quality measures across programs to create a common set of e-quality measures (and reporting standards and guidance).

Second, continue to learn from the fact-base established with Stages 1 and 2 and take a better informed approach to the timing of Stage 3 and availability of its detailed requirements.

- Stage 3 should start no sooner than three years after Stage 2 started, which is, the current CMS plan as confirmed last week in the ONC and CMS certification proposed rule. In addition, CMS and ONC should provide a clear Stage 3 timetable to providers and vendors. I can attest first hand that we and our customers are focused on planning for 2016/17 EHR functionality. Certainly, CMS's December 2013 announcement on Stage 3 timing was useful and positive

- CMS and ONC should allow at least 18 months before the start of Stage 3, and really, before our customers need to be using the next edition of certified EHR technology, for release of Final Rules and also final versions of all associated provider and developer specifications, including certification test methods and tools and quality measure specifications.

- We urge CMS to establish a 90-day or calendar-quarter reporting period for the first year of Stage 3, as was done for Stage 2, to enable load-balanced deployment of the 2017 edition of certified technology before and during the first year of Stage 3.

Third, for certification aspects of Stage 3, and reflecting points from the recent certification hearing:

- Add as few new certification requirements as possible and look for opportunities to eliminate existing requirements; any new or revised items should focus primarily on interoperability and rely on mature standards.

- Consider the impact of new meaningful use and certification items on usability and on development and implementation costs; in this regard, we point you to the excellent work by the EHR Association on likely development costs of various meaningful use and certification requirements proposed by the Policy Committee.

- Try to avoid including immature standards or emerging functions (e.g., advanced population health management tools) in meaningful use or certification as requirements, while, at the same time, constructing measures and criteria for providers and vendors in such a way that they can pilot test new standards and still get credit for applicable meaningful use items, especially those related to interoperability. In addition, in general, CMS and ONC should be more flexible on which standards and functionalities must be used for health information exchange and interoperability to satisfy meaningful use requirements.

- Ensure thorough quality assurance before release of new or revised quality measures, certification test tools, and test data and methods.

- Recognize that changes that "only" affect certification are not cost-free and can lead to the inclusion of non-priority product features, with reduction in usability and in other desired features.

- Understand that eliminating existing well-established or "topped out" meaningful use or certification requirements does not mean that we will eliminate such functionality from our products, especially where there is clear market or program needed for such functionality.

Fourth, new and emerging technologies that enable value-based, accountable, and integrated care should be able to advance in an innovative market-driven manner, and should not, in general, be included in the regulatory model of meaningful use and certification. This recommendation is clearly relevant to the discussions of the panel today on "HIT Support of Advanced Models of Care." It draws on my own personal engagement, and that of my GE colleagues, with our EHRs and other HIT solutions focused on meeting the needs of accountable and integrated care,

As we move from data capture to data communications for coordination to one of intelligent care delivery through informed collaboration, we encourage further interactive partnership and broader participation of key stakeholders in the design phases of Stage 3, just as we are doing now.

- Clearly, EHRs are an important aspect of the overall HIT landscape for new models of care but, while a necessary component and one that should support such models; they are not intended to be sufficient to meet the range of needs of such models.

Moreover, as we shift in the public and private sectors to value-based and outcomes-focused payment models, it is time to shift the EHR incentive program to a greater focus on adoption and meaningful outcomes that moves beyond detailed and prescriptive usage criteria. Overall, market forces are now increasingly driving products as providers seek to succeed in value-based payment and integrated and accountable care.

Closing Remarks

I'd like to close by touching on the third, provider-focused, question asked of the panels for these hearings: "What benefits have you realized in your organization as a result of implementing an EHR and meeting the requirements of stages 1 and 2?" Having spent many hours with our EHR customers individually and with our various user groups, I can report that they see great value from use of their EHRs. These benefits, as reported by our customers and reflected in the literature, include enhanced clinical care, productivity, legible and accessible information, safer prescribing and ordering, use of clinical decision support, care coordination, quality measure use internally and externally, structured data supporting analytics, and more effective patient engagement.

Moreover, without minimizing the importance of interoperability, and the value of connected care delivery systems, within and across provider settings, the claims of some that, without "interoperability EHRs provide little or no value" is not true. Ask any of the many satisfied providers who have invested many dollars and hours in implementation and use of their EHRs.

The EHR incentive program has accelerated the financial and non-financial drivers of EHR adoption and use. That is a signal accomplishment. Together, based on this foundation, we can do much more in Stage 3, which CMS has indicated will be the last stage. We should focus on enabling greater value from Stage 1 and Stage 2 investments and by emphasizing greater levels of standards-based interoperability, focusing on mature standards while also encouraging and enabling innovation in and refinement of newer standards and associated technologies for ubiquitous interoperability and continuously improving outcomes.

Thank you for the opportunity to appear before you today.