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Testimony to HIT Policy Committee: May 20, 2014

Re: Meaningful Use

Thank you for the opportunity to review the experience with Meaningful Use Stages 1 and 2 at Atrius Health, and to share our thoughts about moving toward Stage 3. We have been supportive of Meaningful Use since the beginning of the program, but we now think it is a great time to re-assess where this program should move in the future. The current approach with large scale changes and stages are proving a significant challenge and may in fact be hindering rather than improving electronic patient records as a tool to improve patient outcomes.

Atrius Health is a not-for-profit alliance of six community-based medical groups and a home health care, private-duty nursing and hospice agency. The Atrius Health groups include Dedham Medical Associates, Granite Medical Group, Harvard Vanguard Medical Associates, Reliant Medical Group, South Shore Medical Center, Southboro Medical Group, and VNA Care Network & Hospice. A national leader in delivering high quality, patient-centered accountable care, Atrius Health and its groups make it easier for patients and communities to be healthy. Our organization represents more than 1000 physicians and 2100 other health professionals, with a total of 8700 employees serving nearly one million patients across Eastern and Central Massachusetts. The medical groups and home health agency work together to develop innovative, high quality and efficient models for delivering care in the office, home, and remotely.

Atrius Health has extensive experience with electronic patient records. Our largest group, Harvard Vanguard Medical Associates has been an Epic client for over 20 years and pioneered a home grown electronic record before that. All of the remaining Atrius Health groups have been live on Epic since 2006-2008. We have a fully integrated PACS system, a vibrant patient portal with over 400,000 active patients and a full ambulatory suite of applications. Our enterprise Data Warehouse merges clinical and claims data and supports our extensive work in population health management. Atrius Health is a Pioneer Accountable Care Organization and was the first ambulatory only group to receive HIMSS Stage 7 designation for electronic patient record adoption.

We highlight the above to emphasize our fervent support for electronic patient record adoption as a key strategic decision for Atrius Health and our belief that we can only continue to advance patient care if our entire community continues to press forward with their use and with interoperability.

Despite the challenges, we support the Meaningful Use program and over 80% of our providers have attested for Stage 1 of Meaningful Use, most having completed 3 years of attestation 2011-2013. The majority of the remaining providers are not eligible for Meaningful Use incentives. We have watched with anticipation as this program has helped move the majority of US physicians to electronic patient records over the past 3 years.

Stage 1 of Meaningful Use has created a significant set of challenges but our success with the program demonstrates that they are not insurmountable. Operationally, the consistent review and acknowledgement of specific sections of the patient record (smoking history, problem list, medications, allergies for example) and the provision of clinical summaries and printed after-visit summaries were the most difficult to implement broadly. However, these measures clearly support improved patient care and communication. The more challenging aspects for these measures come in asking clinicians to review medical issues outside of their area of specialty. When an ophthalmologist reviews a medication list or problem list –can they really be expected to update medications or problems added by a cardiologist or nephrologist? They can certainly confirm with a patient what they are taking (or not taking) a medication. But if they are not taking a medication should the ophthalmologist remove it from the medication list if the cardiologist wants the patient to take it? These clinical challenges make a simple action of clicking a "reviewed" button a complex problem that is not easily explainable. Other challenges include the difficulty of preparing and submitting the large number of attestations, and producing and testing the reports that support each attestation. An additional issue relates to providers who practice in multiple locations and settings. Although this has improved since 2011 as other organizations have learned more about Meaningful Use, it continues to be a challenge to document annually exactly where all encounters take place and to get documentation from all of those organizations.

As we continue to prepare for Stage 2 attestation there are significant challenges that are unresolved and some changes that will add clinical complexity. The biggest issues by far relate to clinical summaries and the measures supporting transitions of care and medication reconciliation. The clinical summaries that we produce are replicated in our patient portal so we are fortunate to have a high percentage of patients using our portal. However, the increase in detail required in Stage 2 has a benefit to patients in terms of sharing information but a definite adverse effect of including almost their entire summary record on printed documents. Patients can easily misplace or leave these documents in public view for others to read.

The complexities of the measures around transitions of care make this the largest challenge we have faced thus far. First, consider outbound communication from Atrius Health. We have an extensive referral network and an industry model referral program that tracks referrals from the point they are made, to appointment scheduled, to appointment completed and finally documentation received. We have existing processes for sending referral letters but if we follow Meaningful Use we should send a clinical summary to providers outside of our network with 10% of those being electronic. Exactly when should that summary be sent? If we were to send it on "referral made" a significant number would go to the wrong providers as patients make other choices due to scheduling needs or other priorities-and as previously mentioned that would be disclosing an extensive portion of a patient's record to those individuals who would never see the patient. If we send it on "scheduled status" the correct receiver of information would improve but many referrals are scheduled several

months in advance so sending a clinical summary when the appointment is scheduled may have less accurate information given the lag time before an appointment. In addition, many clinicians have no interest in seeing all of this information, nor does the patient always want to disclose all of this information to a provider managing only a small aspect of their care (physical therapy for example). Finally, and most importantly, Massachusetts is an "opt-in" state for our Health Information Exchange (Mass HIWay). The difficulty of implementing that and the Meaningful Use requirement that we send transactions has created an unusual dichotomy where everyone is preparing to send transactions but as of today no Massachusetts organization has published Direct standard addresses to receive our clinical summaries, so we cannot meet this measure at all as originally intended.

Next, consider inbound communications for Medication reconciliation. We have implemented a "real-time" hospital database where we receive automated ADT (admission, discharge, transfer) notification from some local medical centers. We then trigger messages to clinicians about those events and use our discharge nursing program to ensure patient follow-up. We then ask providers to document medication reconciliation at the next appointment. However, many transitions of care do not have the above notification and again the timing of the messaging and the most-appropriate time to perform medication reconciliation is a significant workflow challenge. It is frequent that medication reconciliation would have taken place when the patient arrives with printed discharge information the day following an ER visit, but then a few days later a summary will get scanned and would then add to the measure denominator as a new event. We understand the important patient safety implication of this work and had it in place prior to the Meaningful Use designation, but accounting for the transitions to measure it in a valuable way is still a significant challenge despite our advanced systems.

We believe that we will begin to be able to attest for Stage 2 for some providers beginning Q3 in 2014, and are hopeful that the remainder will be successful following Q4. However, to be in May, 2014 and still so unsure about our success in Stage 2 should serve as a harbinger for you that most EP's nationally in 2014 will not meet this hurdle.

We are hoping that the above gives you significant pause about moving on to Stage 3. It is our view that it will take about 5 years before we can fully assess the impact of all of this work. Like you, we consistently want to demonstrate the importance of our work on patient outcomes. Simply raising the bar on technology may in fact reduce the success of Meaningful Use by focusing all the resources on meeting the needs of the program in the hopes it will improve outcome but without any real data. Our recommendation to you is fairly straightforward.

First, make Stage 2 the final "stage" of meaningful use. Second, every 3-5 years, use your extensive system knowledge and industry perspective to add a small number of features as a minimum base for certification and then measure outcomes-not just process- from clinician groups and hospitals-so we can refine reporting and comparative metrics over time. The current stage jumps are just too large to absorb and as you have seen from your thoughtful delays, are harder to achieve than anyone thought at the outset.

Some examples may help to clarify our position. One of the best features of Meaningful Use has been the push for standardized transactions to enable interoperability. As the current Stage 2

completes in 2016, one might consider adding for 2017 features that improve the ability to send and receive data between disparate systems and same-vendor systems as required to certify vendors ongoing. The continued improvement in interoperability should allow systems to enhance care. In addition, you may want to certify vendors to allow for patient-entered data by questionnaires or devices (not necessarily both) or access to that information by a view portal. For Eligible Providers, you now add the requirement to receive transactions for example to a set of existing criteria. For reporting you allow for a measure specifically around follow-up from ER care or inpatient discharge as an outcome measure or re-hospitalization. This now becomes the ongoing CMS EHR standard. A lighter lift overall will replace or add to existing requirements that were adopted in Stage 2. Instead of forcing more workflow around electronic messaging, this type of approach could compare outcomes or patient satisfaction related to using electronic tools in their care without a "threshold" requirement for use of the tools so that we demonstrate value as we move forward.

As we transition into the "penalty" phase of Meaningful Use, there will be many EP's and hospitals that cannot reach Stage 2. Planning a Stage3 right now will hinder your progress and program. Moving forward with a long-term designation that EHR use and reporting will be required for CMS payment makes sense. The goal of setting a successful and ongoing standard for technology availability and reporting on the outcomes supported by technology will go a long way toward helping all of us achieve the Triple Aim. In addition, current transitions in the payer market will have a much stronger influence on the sensible adoption of technology and inform where we can find value. It is imperative that we remember that technology should be an enabling tool, and it is the use of that technology that spirits change, not changes in the technology itself.

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