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Meaningful Use 2 (MU2) has required some very heavy lifting to get to where we are today. At this moment, May 15, 2014, we are on target to meet all requirements for MU2. Our biggest challenges can be put into four categories:

A) State Reportables
B) Referral sites state of readiness for Direct Secure Messaging (DSM), and one instance where the required DSM method of delivery is a quantum step backwards from the HL7 automated messaging already running directly into an independent providers groups EHR. These interfaces have existed for nearly 10 years. They include all results, all transcription, all reports, CCD, and ADT. Yet the requirement is we send them a CCD via DSM. They already have them integrated into the system. As a physician stated: "We are doing meaningless work for meaningful use".
C) Accountability for things beyond our control: Portal usage and referrals are prime examples.
D) Time to optimize operational work flows of the required changes

State Reportables: At the time we installed our MU2 certified 2014 code in September of 2013, the state of Iowa was not prepared to accept labs, immunizations or Syndromic surveillance. Immunizations are now live, via HL7 messaging bi-directional (immunizations to the state and a history from the state), and we have completed this interface.

Labs are due to be live by July 1. We are in testing of that interface now. This process requires a vast knowledge of SnoMed and LOINC coding, by someone intimately knowledgeable in the laboratory field. I fear this combination of skills may be rare in rural facilities. We are blessed with a Lab Director who has handled this masterfully, but many others with whom I have spoken are struggling. The Iowa reportables have to run thru a product called SmartLab. Simply put this is a mapping front end tool at the state. It is not rocket science to do the mapping, but it is exceptionally detailed. It requires the learning of navigation in yet another system to perfect the set up. My Lab Director and I personally handled this mapping. It is tedious, and detailed, but we survived. Again I fear for resource availability at small facilities to get this work done.

The state of Iowa has no Syndromic reporting at this time.

The State HIE is called IHIN (Iowa Health Information Network). This requires exchanging CCD documents to the state that can be queried by others. This turned out to be more difficult than first blush would have one believe. Apparently there are different interpretations of the requirements for a valid CCD and its tenant packaging, depending on EHR vendor. This required some intervention of the IHIN governance structure to define what IHIN would utilize.

All in, our costs to our EHR vendor for these interfaces totaled $50,000, plus all of our time. Syndromic reporting will add a cost of $5,000-$10,000 to that total when Iowa implements. While incentive dollars assist with this cost, it is of significance, especially to a facility of our size.

Referral Sites: The transitions of care (ToC) measures are admirable in their intent and offer a great opportunity to improve care and enhance outcomes. My organization embraces this concept warmly. Our system produces a CCD document on every patient visit immediately. So the 50% should have been, and actually was, a non-issue. However, the requirement to send 10% via Direct Secure Messaging

(DSM), was an enormous challenge. We were ready and able to send the documents via DSM, but had no one to send them to on April 1, the beginning of our attestation period.

We are a small Critical Access Hospital, 25 acute beds plus 49 long term care beds. The LTC shares our EHR, so they would not qualify as a referral, nor would a Transition document be required as it is all one EHR. Larger hospitals in our referral pattern were not ready to accept the documents on April 1, nor are they today (getting very close however). Patients transitioned home, but referred for follow up with their Primary Care Physician (PCP), presented our only opportunity. Our main PCP group, representing 75% of our admissions, were not ready to accept these documents on April 1. They are about a month away from installing their 2014 code, and hence not prepared at this time. They however, have until December 31 while we had only until September 30 to meet MU2. The solution was a Medical Mail Box that meets the required measure but is rarely used by them. As stated above, we already have HL7 interfaces direct to their EHR, and have had for 10 year, that already gave them more than a CCD document can, and they get the CCD as well, via the interfaces already in place. This was a frustrating challenge for them and us. They saw no value in taking a step backwards, yet we had to do it to meet the requirement. It is doubtful that we could meet the percentage today (even at 10% for DSM) if all of our referral hospitals were live. I calculate we would be in the 6-8% range with the hospitals. When I look at the LTC facilities in the area to whom we discharge, none are ready, nor actually willing to receive the documents for ToC. This is a huge challenge in rural America (perhaps urban as well). Talking to fellow rural colleagues, virtually all are facing similar issues.

Accountability for Measures beyond our Control: This essentially focuses on the usage of the patient portal. The first View, Download, Transmit (VDT) measure requires information be available within 36 hours. To us that is a non-issue, or should have been. Our system creates a CCD upon demand or at discharge. Easy enough in that 100% of the time it is there. The difference is when it is created it can be the completeness of the CCD, but it is always available. Things like cultures take some time, but 36 hours covers almost all and there is something available 100% of the time within that period. The problem came with interpretation of the measure requirement, and when did the patient have the information required to access the portal if they chose to. Solving that problem required out EHR partner to make some significant revision to portal access design. They did this in record time, but that cost us the ability to attest in Q1 of FY14.

I have mixed emotions about measure 2: 5% actually use the VDT capability. This we have absolutely no direct control over, yet are subject to reimbursement penalties if we fail to meet it. However, as we have learned, we do have significant influence on this measure. We have gone to a process of walking the patient thru portal set up and initial access at discharge. This is more easily done for in patients as you have more time. Out patients present a challenge, but we are working on those as well. The mix of emotions is this: I believe we are being held accountable and possibly punished for something we cannot control. We cannot force a patient to use our portal. Yet the other side of the coin is this: Would we expend the same effort to influence usage absent the possibility of penalty. Right now, we believe the efforts we are expending, and they are significant, are in the best interest of our patients and therefore us and healthcare in general. Clearly engaging the patient is a key to bending the cost curve. This is a step in the right direction.

It does trouble us a bit, however: 55% of our patient population are Medicare and another 20% are Title XIX. Their access to, and willingness to use a computer are questionable in some cases. We do provide

over 15 computers for public use in the hospital. And yes, my 89 year old mother has one at home and uses it every day, but in rural areas, this can be a challenge, or at least in our service area it is.

While this area has been a challenge, with some creativity, it is doable. I would, however caution about raising the thresholds too high. Right now we are only hitting about 8% portal usage with the efforts to date. We expect that to climb, but personally, I would predict topping out in the 20-25% range in our patient base. I cannot prove those numbers, but they are what I see today.

Workflow Optimization: My hospital began the EHR journey in 2004. We implemented CPOE in 2008, a physician portal in 2005, nursing notes in 2004, electronic med administration in 2004, template driven physician documentation in 2011 and the list goes on. Since ARRA was signed in February 2009, HITECH provisions have been being defined since. Twice during the ensuing five years our EHR partner has had to rewrite the application completely to accommodate mandated MU measures, and we had to implement those changes. Admittedly, all of the measures have been focused in the directions that we need to move healthcare, but the amount of change we have asked clinicians, especially physicians, to adapt to, has been amazing, if not overwhelming. The EHR vendor community nearly universally admits that some things have been added to applications just to meet the requirements, with little or no consideration as to the impact on work flows.

I would not suggest for a moment that any measures be eliminated. I would however, plead for a period of time following MU2, to allow the community as a whole (both the EHR partners and the providers) to optimize work already done. We need to go back and fix processes to make them more efficient and time sensitive for the providers. They work today, but they are not pretty in some instances.

I believe that the delay of ICD-10 punished those who responded to CMS direction in favor of those who did not. My organization was well prepared and ready to move. Many dollars had been spent on training, system upgrades and testing. Much of that may be wasted if CMS is not ready to take ICD-10 claims in October. I believe the industry would have been far better off, to have stayed the course on ICD-10 and delayed the penalty date for MU2 by a year. That delay in MU2 penalties would have allowed some time to focus on the optimization of work flows of which I speak here. The ship has sailed on that one for now, but allowing time for this optimization is critical. I fear that should we not take time to optimize work flows, physicians in particular, may simply refuse to use the tools we have so painstakingly built. All would be lost then. I would implore ONC to consider favorably such a period of time dedicated to process and workflow optimization.

We need to consider the pace at which MU2 is being attested. That may well be a warning of things to come should we fail to look at workflow optimization. I believe that optimization is simply a matter of time being allowed for the efforts, dedication by our EHR partners and our users, and the boots on the ground efforts to make optimization happen.

Finally, I recognize that my organization had a huge head start on MU1 having begun the journey in 2004. MU2 has been some significant heavy lifting. We are there, but it has been a challenge.

The true elephant in the room is the issue of security. While we have done everything we know how to do to this point, new threats emerge all the time. My fear is that an incident, over which we have no control, and may be a direct result of criminal activity on the part of others, exposes my organization and our patients. Yet we have done everything we know how to do to prevent it, we are still exposed,

and the penalties could well mean closure for some hospitals. That thought alone, keeps CIO's awake many a night considering what else can be done. A Cybersecurity framework that is both scalable and affordable; effective yet administratively executable, is desperately needed. Much progress has been made, but much more is in front of us as the evolution of threats will only continue to grow.

I think it is critically important for all of us to remember, how far the industry has come in the last five years. Going forward, the challenge is to sustain that momentum, and accelerate it. Focus on patient engagement for stage 3 is of significant importance. To make an impact overall, that patient must be integrally involved in the process of their health, not a bystander or observer. I for one quit smoking after many years, four years ago. I am working on shedding some excess baggage now, but many are not so engaged. That one is critical.

Creating a Cybersecurity framework that is both sustainable and affordable, while simultaneously effective should also be a very high priority. However, in so doing we have to be cognizant of the resource, both human and financial, issues that are faced, especially in smaller and rural facilities. Scalability of such a framework to fit down to the small few physician practice, thru a small facility like mine, to the giant systems and facilities, is what the industry needs.

Finally, interoperability cannot be over emphasized. We absolutely have to find ways to make inter system communication and data exchange both affordable and feasible. I believe we must be sensitive to what our EHR partners have to work with and the scope of the efforts required. To me this means, simply, standards. Reasonable, enforceable and universal standards. From our experience I can tell you that in HIE implementation I learned that not all CCD documents are the same and not all EHR's can easily read each other's documents. Reminds me somewhat of electronic claims, we have lots of data standards for 5010 and such, yet individual payers have differing content requirements and/or billing requirements. We must avoid this scenario if we are to achieve the level of interoperability that will actually drive the results all of us expect, want and desperately need. Only that level of interoperability will better serve the patients and contribute to bending the cost curve of healthcare.

If it were easy, it would be done by now. Common Well Health Alliance holds strong promise, but any alliance needs to be universal in scope, and must have the buy in of the regulators. Remembering to keep the process of defining and executing interoperability scalable, affordable, and executable by all is the only domain in which I can see all of us succeeding.

However, just May 15, I participated on a conference call with ONC and the VA relative to exchange of CCD documents via direct secure messaging. In that call, the VA announced a new requirement for DSM, utilizing an FBCA certificate to further enhance security. The Direct Trust HISP members do not all support FBCA, not all implementations that meet ONC requirements support FBCA, yet we have two different entities of the US Government dictating two different sets of specifications for DSM. With that level of disconnect at the federal level, it is difficult to even imagine how we can get to true interoperability. If the rules of engagement can be changed that easily, the task of interoperating may not be achievable. To that end, I implore CMS to drive towards universally accepted standards and that those standards be endorsed by all regulating bodies at the federal level, at a minimum.

I want to thank the Office of the National Coordinator for the opportunity to submit this testimony. Though we are a small, rural facility, we are dedicated to the ends for which I believe we all strive. To be

heard and listened to, is a great step in the right direction. My hospital and I remain committed to this journey, and are ready to contribute to this process in any way we can.