

## Questions/Answers for Eligible Providers Panel

### Implementation/Usability Hearing, July 23–24, 2013

Implementation, Meaningful Use, and Certification/Adoption Workgroups

Submitted by:

#### **Craig Bradley, MD**

- Chief Medical Information Officer, Texas Tech Physicians of Lubbock
- Assistant Professor, Family Medicine, Texas Tech University HSC School of Medicine

### **As you assess your readiness for stage 2, what objectives pose the greatest challenge? What is your approach for addressing those challenges.**

- **Measure 7, part 2** requiring 5% of users to view, download, or transmit their health information. Of course, all providers find a measure such as this, where performance is in the hands of patients and therefore difficult to guarantee, concerning. Recognizing, though, that this is essentially an outcome performance requirement, EPs are coming to grips with this outcomes based future reality. One of our main concerns is that in order to meet the letter of this requirement, vendors and EPs may build into their patient portals a semi-automated walkthrough. This is not necessarily a bad thing, but might allow us to meet the requirement technically while still not achieving the goal of more engaged patients. We are, however, aggressively marketing our patient portal to two populations, our patients (a receptive market) and our EPs (somewhat less receptive in many cases).
- **Measure 15** is, frankly, a bear for our EPs and our vendor (as a menu objective, we skipped it in Stage 1). What is a transition of care for an orthopedic surgeon or any other specialist in the ambulatory setting? How will we identify transitions in our EHR? What about the transitions that we find out about via records request, but do not initiate? Can (or should) one transition from a hospital to another setting count for both the EH and the EP? This measure is also not in the complete control of the EP, as electronic transmission, no matter your promiscuity, requires a receptive partner. To address this final issue, our EHR partner group (two multi-specialty practices and a hospital) have partnered with the other major healthcare entity in our service area to create a local HIE which will include approximately 80% of the lives in the area. Many of our EPs will likely be exempt from the measure, however, since as two multi-specialty practices and a hospital sharing an EHR, a large percentage of our transitions occur within that shared EHR.
- **Closing the Referral Loop** - an excellent quality measure that we need to implement but for which our EHR and our current referral workflows do not have a particularly elegant solution.

### **How well does the meaningful use program address the needs of specialists?**

- Poorly (but that might not be a bad thing). Obviously, the program is built to improve and change the holistic care of the patient with a focus on chronic condition management, and in

the currently structured healthcare system in the United States, a holistic view of patients is (with few exceptions) the province of primary care.

**How would you improve the design of the meaningful use incentive program for your specialty or practice discipline? What are your suggestions for enabling greater levels of participation by specialists (e.g. measure definition, quality measures related to physician specialties, attestation timelines)?**

- (NOTE: As a representative of a large multi-specialty academic organization, I will not answer the first question (I am a family physician and the incentive program was more or less designed for me) but will discuss specialists in more general terms)
- This is—obviously—a difficult question. If the long term goal is the maintenance of something resembling the status quo for healthcare in America, then there may be a couple of options:  
**Option 1: Reframe Meaningful Use for specialists to be very limited**, and to be in support of the primary care and health of the patient. In other words, specialists participate in problem lists and medication lists and have increased requirements around surgical histories and/or diagnostic reporting, dependent on specialty, but don't really participate in the broader concept of Meaningful Use.
- **Option 2: Implement a specialty-based Meaningful Use program**, individualized by specialty. Dermatologists would have a different incentive program than Urologists, and so on. Especially from a quality reporting perspective, but also including the functional measures, the work of different specialties varies widely, and their meaningful use should be based on what they actually do.
- If the status quo is not a god we must serve, then...**Option 3:** (NOTE: I will temporarily stop speaking on behalf of my organization and just speak for myself on this one) **Pursue wholesale restructuring of the healthcare system in America.** There is almost nothing about the current system that is built for efficiency or centered around patients. The meaningful use incentive program and HIT reform are noble attempts to gently nudge entrenched institutions towards innovation, but lipstick won't make this pig any prettier. We pay more for shorter lives than any other industrialized nation. Is the current payment and payor system a long term solution? Do current specialty definitions even make sense in light of 21st century technology? And can either of those two questions be addressed without first addressing the other (chicken or egg)? That said, I do appreciate the near-futility of such thinking, and will therefore return to the regularly scheduled programming, wherein we discuss more realistic efforts.

**What do you believe are the main reasons why certain eligible providers may be electing not to participate in the program? How best might ONC and CMS encourage their participation?**

- In a large multi-specialty practice, like ours, specialists probably do participate because they can benefit from the work done by and for the rest of the practice (see above on how MU could be made more specialty specific) AND because the dollars in a large group are simply large enough

to discourage avoidance. In smaller groups, though, the \$44,000 total incentive split up over five years simply isn't enough to invest the amount of work required. Do you know how much a cardiologist gets paid for an angioplasty and stent placement? And if meaningful use retards ambulatory productivity by even just 5%, surgical volume for some specialists will consequently reduce by 5%. \$44,000 doesn't add up. Especially in light of the still immature state of EHR readiness and the uncertain workflow adaptations that will be required. As I type this, it is but 2 months until Stage 2 attestation could/should begin for EHs (and only 5 months for EPs) and our vendor has, as yet, not even finalized functionality or workflow suggestions. So, without a dedicated EHR adoption team at the ready, how could a small group be ready to roll out new workflows on very short timelines? And, to be frank, specialists probably generally doubt that payment reform will really happen in a way that requires them to adopt. That said, the specialists in our group are participating.

- Participation could be encouraged by building specialty specific Meaningful Use guidelines. A consideration of larger stimulus payments might be of some motivational value as well, but if specialists consider the financial benefit to be insignificant, then perhaps that speaks more to the aforementioned status quo.

### **What guidance or actions by HHS may be most conducive to increased adoption of the public health reporting standards including transport standards?**

- It's obvious, right? 50 states, some 3000 counties, about 30,000 municipalities. Many with agencies to which they'd like reporting. The tiniest allowance for flexibility, however well-intentioned, multiplies among those many entities to create widely varying processes. A big part of the difficulty in adopting these standards is in the variable ability to accept reporting in HL7 standardized formats with universally translatable standards.
- On this end, then, limiting what is reported and not allowing any variability might help. Start slow and build.
- Alternatively, HHS or another federal entity could/should serve as a clearinghouse for this reporting. Then, a state or local entity has only one interface to build, with this federal entity. Do the math. (100 vendors x 1 clearinghouse) + (1 clearinghouse x 3000 entities to report to) = 3100 interfaces to be built. Or: 100 vendors x 3100 vendors = 310,000 interfaces to be built. Oversimplified to be sure, but not entirely ludicrous. Could only make sense if you're the one selling the interface. See below.
- Another issue is with vendors utilizing these and other measures as a means to add additional licensing. "Yes, Dr. E.P., we certainly are a certified EHR and you certainly can use our EHR to report to public health agencies. Here's the price tag on that added functionality."

**An aside on solution certification. Not one of the questions I was asked to answer, but an issue on which there is comment to be made, and which is in part related to the answer to the previous question.**

- Certification of solutions was a concept created to set a minimum standard to which vendors must comply and to remove the risk from EPs/EHs in selecting an EHR. The ability to use a piecemeal certification process was a concession to accommodate health systems or practices who were already using multiple solutions. At our institution, and certainly in the majority of EP practices, we use (for all practical purposes) the complete EHR solution from a single vendor. Unfortunately, essentially every aspect of meaningful use which they hadn't already built when MU came along is an opportunity for additional licensing fees. Wasn't certification meant to ensure that all vendors complied with a minimum level of functionality, and as an aid to the EP/EH to simplify EHR selection? What has instead occurred is that EP/EHs must assess their EHR and determine what pieces of certification it has excised and then purchase those pieces from that vendor. The burden of certification has not only been pushed from its intended target, vendors, out to the EPs and EHs, but those vendors have also leveraged (created?) that scenario as a new revenue stream. Envision a naïve, small multi-specialty group of EPs, coming to Meaningful Use after already using an EHR for several years. They bought the EHR from one of the big vendors, Vendor X, when MU was known but on the distant horizon. Assured by Vendor X and common sense that they were purchasing a solution that would become certified, they are now ill equipped financially or even logistically to deal now with buying (and implementing) several additional modules to add on to their EHR in order to make it certified.
  - I know that some vendors have taken the position with Stage 1 that the EP/EH must own every solution for every menu measure in order to claim certification, even when they were choosing not to implement certain of those menu measures. This simply cannot have been the intent of certification.

**What meaningful use objectives do you believe should be given highest priority for their inclusion in Stage 3 and why?**

- First, I do not believe retiring measures, in particular the vital signs measure, makes particular sense. In our multi-specialty practice, primary care EPs have derived substantial benefit from having specialists more routinely collect this information. Vital signs in particular, when obtained in other venues besides the primary care office, are valuable. I assume that you assume that since compliance has been achieved, it will continue. I do not think this is a given.
- Submission of patient-generated health information is a good step in the right direction and should definitely be prioritized.
- The measure to allow patients to request online amendments to record is absolutely an excellent idea in spirit. I fear, though, that without a great deal of specificity, the solution will be to simply add a free text messaging functionality from the online pages where a patient is participating in VDT. Allowing vendors and EPs to meet this goal on a technicality would be a great shame. Instead, it must be that patients will be allowed to request changes and those

requests should be directly attached to items already in their record. For example, a patient is reviewing her chart and finds that she is recorded to have had a total abdominal hysterectomy with oophorectomy. In fact, her ovaries continue to occupy her pelvis. She should be able to append her comments directly to that surgical history item, so that anyone reviewing her surgical history would see her annotations. If she simply sends a message to an unspecified recipient in the clinic, there is a great chance that her comments will not carry through to a point where care providers see them. As I will I hope make clear in this document and in my verbal report, I fear that in some ways we are racing far ahead of our ability to populate the records with highly accurate data.

- Referral loop closure warrants high prioritization.
- I would like to see a measure that requires reporting of clinical decision support statistics. Having EPs review the number of alerts they override compared to the ones which result in a modification of behavior is a vitally important tool for two reasons. First, it helps to reinforce the importance of said measures. Second, it is important to review and prune the clinical decision support alerts. As we all know, alert fatigue is a real problem and reviewing the signal to noise ratio of these alerts should be required.
- Vendors should be required for certification to allow for the recording of genetic information in some way. There are DNA snips that we know with a fair amount of certainty could be useful for clinical decision support in terms of prescribing, treating, or screening. There is no time like the present to require EHR vendors to start grappling with this.
- Require EPs, EHs, and vendors to maintain and report on HIT related errors and incidents.

**By stage 3, we believe qualifying for Meaningful Use (MU) will be quite mature. That would allow us to focus more on outcomes of using an EHR and less on “process,” the functional requirements.**

- This isn't the question yet, but I'd like to respond. I take exception with your conclusion. Attesting for the measurements which allow for Meaningful Use stimulus funds to be received will be mature. That does not mean everyone is meaningfully use HIT. With the fairly rapid pace of adoption required for meaningful use, I strongly suspect that a non-trivial percentage of attesting EPs and EHs have done so on an equally non-trivial percentage of the measures in a manner that meets letter of the law but not necessarily the spirit of the law. As an example, I recently polled about 15 of my colleagues at other institutions or large practices with this simple question. What percentage of the patients in your EHR have a fully populated and completely accurate problem list, past medical history, family history, and surgical history? The consensus at the conclusion of our discussion was alarming. As a group, we settled on 25%. This is why I think the most important measures for Stage 3 are the ones that allow patients to interact with their own medical records. Patients are the key pieces in building accuracy. Pushing more clinical decision support on data that is not pristine is going to result in disappointment. I would agree that outcome based measurements mitigate for this to some extent, but the creators of the

measures bear a measure of responsibility in defining them in a way that requires accuracy. The Stage 1 problem list measure, as an example, does not. Or, is it that we can never count on accuracy in the human generated pieces of the EHR, and that the only reliable triggers for clinical decision support will be the fully objective components, like labs and vital signs and medications? In any event, pay attention to that horse lest you find yourself alone with a cart to push.

### **Deeming.**

- BP quality measures could deem satisfaction of vital signs functional measures, as could obesity counseling.
- Tobacco quality measures could deem satisfaction of tobacco functional measures.
- I don't have much else to add on this point.

### **What have you found to be the most effective use of HIT to enable consumers to be active participants in their own healthcare? What are the most important barriers meaningful use could address to promote more effective patient engagement?**

- We are struggling in this regard. Where EPs are willing, patients appreciate our online patient portal. However, many online patient portals are the bastard stepchildren of the beautiful marketing based websites that stand beside them. It is my suspicion that the systems where the patient portal and the marketing website are irrevocably intertwined are the most successful but are also rare. Nevertheless, despite a clunky and unattractive interface, we do have a small population of patients actively engaged in our online patient portal.
- I actually believe that fear of change among the healthcare community is the greatest barrier. On the one hand, a billion people share on Facebook and in polls most of them would even discuss their healthcare issues on that platform, even though it is famously indifferent to the concept of privacy. On the other hand, though, medicine in America is the last industry to continue to use pagers and fax machines as required daily tools. Fear of change and the fact that modern America has created a subclass of extremely wealthy physicians desperate to maintain the status quo are both tremendous obstacles to innovation. As far as meaningful use making a dent in this, how about requiring that all patients have access to every single part of their medical record at any time. Force complete transparency on us. But while you're at it, also fix the legal system so that physicians fear that transparency less.

### **Do you currently send and/or receive electronic transitions of care information with other healthcare providers including skilled nursing facilities (SNF) and home care agencies (HC) caring for your patients ?**

- No

**What are the most important actions vendors can take in support of attestation?**

- Prescribe workflows and standardization of processes.
- Commit to usability and, dare I say, delight. Both in current R&D, but also as an aggressive retrofit.
- Create functional reporting tools early.
- Build in audit preparation tools.
- You didn't ask, but HHS and CMS need to consolidate all quality reporting and electronic prescribing reporting and other reporting for EPs under the single banner of Meaningful Use. Yesterday, not tomorrow.

**Should CMS take additional steps to provide EPs guidance on how to prepare for audit of meaningful use attestation? If so, what suggestions do you have as to what those steps should be?**

- Make inclusion of audit preparation tools (at no additional cost) a requirement for vendor certification.
- Move the burden of certification back to vendors, where it belongs.
- Reform and consolidate all CMS auditing (not just meaningful use) under a single banner. Focus on education, not fear.