Response to Questions for
The HIT Standards and Policy Committees Workgroups
Public Meeting on the Implementation and Usability of Meaningful Use

by

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Background

The Regional Extension Assistance Center for HIT (REACH) is a program of Key Health Alliance (KHA) working in collaboration with North Dakota Health Care Review (NDHCR) and the Center for Rural Health, University of North Dakota School of Medicine and Health Sciences to serve as ONC's Regional Extension Center (REC) for Minnesota and North Dakota. Key Health Alliance (KHA) is a partnership of Stratis Health, National Rural Health Resource Center (Center), and The College of St. Scholastica (CSS)—all committed to advancing health information technology (HIT), with emphasis on rural and underserved areas.

REACH is integrated with local HIT activities and stakeholders

REACH has developed a Minnesota Council and a North Dakota Council with representatives from state HIT/HIE organizations (section 3013), state Medicaid agencies, universities, medical associations, state departments of health, and state Medicare Quality Improvement Organizations (QIO). The REACH program plays an active role in many ARRA programs including: curriculum development with the University of Minnesota UP-HI program; Community College Consortia with Normandale Community College and Lake Region State College; Beacon; and HIT/HIE ARRA programs.

REACH program impact

The REACH program committed to provide technical assistance to 3,600 priority primary care providers (PPCP) to achieve meaningful use. As of July 1 2013, the REACH program has signed up 4,907 PPCPs, 136% of its intended goal of 3,600 PPCPs with 2167 of them (60% of goal) achieving meaningful use. Additionally, with the Critical Access Hospital (CAH)/rural hospital supplement announced in September 2010, the REACH program committed to provide services to 124 hospitals across Minnesota and North Dakota. As of July 1 2013, REACH has signed up over 117 CAH/rural hospitals for services or 94% of eligible hospitals with 58 of them(40% of goal) achieving meaningful use.

1. Stage 2

a. What objectives pose the greatest challenge?

When thinking about what objectives would pose the greatest challenges, we're most concerned with the challenges experienced by critical access hospitals and small rural clinics. Many of the larger integrated delivery systems within our community have the IT staff and expertise to redesign their workflow and understand the technical requirements the objectives and measures require. The smaller facilities do not have easy access to these resources outside of the services Extension Centers provide. This is of greatest concern to us going forward.

The expanded number of CDS interventions may prove to be difficult for those who do not have the technical skills to produce interventions that they find valuable or do not have a true understanding of the breadth and depth of what constitute CDS interventions. In our conversations with providers, the default language is 'alerts' and the narrower 'pop up' window perception of what constitutes CDS. Additionally, subspecialty appropriate CDS interventions are not likely to be built into standard EHR software.

Given out experience with the defunct HIE test for stage 1, the HIE is also likely to be challenging. Difficulties arose surrounding with whom the organization would exchange and we often worked with them to register for Direct. For Stage 2, this will require working with the vendor to understand how their EHR will accomplish the exchange. Based on the technical requirements, organizations will be turning to their IT support staff as well or the experts in HIE at their vendor's help desk. Other issues include having to pay more for new interfaces, uncertainty about when and whether the state will provide the infrastructure to exchange data with other organizations and to send, as an example, immunization data to the state, how to capture all the data elements listed for transition of care documents, and where in the workflow providers can remove diagnostic test results before an AVS goes to the patient portal. These issues are prime candidates for HIT/REC consultant assistance.

Imaging results may prove to be another area where technical assistance will be required. This may depend largely on the topography of the organization's systems and the ability to interface between the EHR and imaging system. For small provider groups, the transmission of imaging results will be more complicated for those who have a contracted radiologist come onsite to read films & studies or read them remotely. In many cases the contracted radiologists work in a group that has there own imaging reporting system that needs to be interfaced with the clinic electronic record for which they are providing outreach services.

The cancer registry menu option would benefit from the same type of assistance provided for the immunization registry. What options are there for MN and ND in this area (as well as nationwide) and it there a standard file format (such as the HL7 2.3.1 what MIIC uses)?

Providers are concerned about how they will motivate & then sustain patients' motivation to respond to information on line provided through a shared portal or online options, despite the relatively small percentage required

Finally, Privacy and Security and everything related to interoperability. Regarding P&S, I think it is being presented in a way that makes it sound more difficult than it is especially for small clinics.

b. What is your approach for addressing those challenges?

The two most important elements for addressing these challenges are technical assistance and education. Again, for large integrated delivery systems, much of the technical assistance and expertise can be found internally. For critical access hospitals, rural clinics and small physician practices, this expertise will need to be found externally. The support can be provided by the local AHEC, an extension center or the provider's vendor. As an extension center, our approach is to provide education for clients and build cooperation between similar organizations.

As we stated above, our concerns are about the rural hospitals, providers and those serving the underserved. We are trying to devise inexpensive options to support them but hope there will be a way to continue to support the work RECs do. Our clients have come to depend on us because a) they trust us; b) they don't have internal resources or time to do the level of research it takes to get answers when the new rules (Stage 2 & 3) come out. Perhaps another subsidy for the work and clients would pay a reduced fee, or sliding scale or something? It would be a shame to discard the great infrastructure of support that the RECs have provided moving 133K primacy care providers to meaningful use.

2. **Specialists:**

   a. **How well does the meaningful use program address the needs of specialists? 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)? What kinds of resources do you believe most important and useful for ONC and CMS to provide or to support so as to enable increasing the level of provider adoption within your specialty or practice discipline?**

   Since I am not a specialist and since we service few specialists, we have limited response to this question. Many specialists have complained that the program does not apply to them, and we see that many of the quality measures and other criteria are of marginal used them. I believe the ONC and CMS should reach out to specialty organizations in order for them to find what they believe is appropriate for their specialties in terms of criteria and quality measures. This includes those criteria which they believe falls outside of their scope of practice. The design of specialty criteria and measures should take into account optimizing care coordination among the patient's multiple providers, locations of care and for information access by the patient.

3. **Non-participation**

   a. **What do you believe are the main reasons why certain eligible providers may be electing not to participate in the program?**

   The typical reasons we hear are that a provider will retire soon, small amount of Medicare Part B that a provider is billing compared to the difficulty and cost of the transition, a lack of belief that it will improve care and, on occasion, “It is just another way for the government to control what I am doing.” Temporary reasons for non-participation is that practice is in the transition of being sold/bought or changing locations.

   In terms of the difficulty and cost of the transition, the ongoing accelerating expectations of the program and the time required to stay abreast of them places additional burden. Not meeting just one objective that the provider sees as challenging or of little value to their practice would eliminate incentive payments.

   Sadly, some rural providers are not eligible, and some CAH Method 2 billing providers only became eligible for incentives this year. These folks either did not have an incentive or else are behind.

   b. **How best might ONC and CMS encourage their participation?**

   This is a difficult question to answer. For specialists, the pressure that may come from primary care providers who want referral information to come back electronically and from patients who want their health information to all be in one place may increase participation. Consequently, the continued outreach to patients so that they demand their providers use electronic health records would be of value. Also patient demand will increase when they are able to compare performance and quality numbers for providers, clinics, and hospitals.

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

Stage III feature of having the immunization registry provide information to the provider as well as predicting the immunizations that are needed would help. Also, reaching out to patients who are due for immunizations to get them to come in. Calculating what immunizations are needed can be especially difficult in the pediatric population when they fall behind in their immunizations. Rather than having each EHR vendor or clinic build it, building it once by the CDC and distributed by the states to take into account local shortages or outbreaks would be a value add for providers.

4. **Stage 3**

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

One objective that will be important for stage III this is significant increase in the requirement for provider notes. Recommended for Stage III is that less than one third of the patients in the hospital will have one note and less than one third of the patients seen by a provider during the reporting period will have one note. This requirement is abysmal especially in the hospital when there are multiple providers caring for a patient. The only way to truly transition from paper to an electronic health record and eliminate the risk of having information in two different places is to fully migrate to an electronic health record. Doing that requires that the documentation be in the electronic health record and not on paper.

Incorporation of patient generated data is another element that I believe to be important. Done correctly, it has the potential of being a timesaver for the clinic and provider as well as assuring the information is current and accurate. Directly imported data from patient owned devices such as blood pressure cuffs, glucose monitors, weights and physical activity will paint a more complete picture of the patient for the provider. This must be done in such a way as not to overwhelm the provider but rather give them useful information when it's needed.

5. **Deeming**

a. **What clinical quality measures could deem functional objectives**

Any number of the quality measures which measure appropriate care and which would depend upon functional objective in order to demonstrate good results.

b. **Which functional objectives are the best candidates for deeming?**

The number of clinical decision support interventions, patient reminders and patient lists by specific condition are three that come to mind. We wholeheartedly support the idea of deeming and believe this was the original intent for stage III of meaningful use when it was first conceived.

6. Consumers

a. What have you found to be the most effective use of HIT to enable consumers to be active participants in their healthcare?

When providers begin to give patients after visit summaries, patients become more involved. When patients have access to their records online and the ability to interact with their provider online, this also helps patients to feel more empowered and engaged. In the exam room, when the provider turns to the monitor towards the patient so it is a shared record, this also increases patient participation. Finally, providers use the EHR to collaborate with their patients also leads to greater patient participation.

b. What are the most important barriers meaningful use could address to promote more effective patient engagement?

Barriers that meaningful use can address would be the ability for patients to enter information into their electronic health record and to be able to consolidate the record from multiple providers into one place. Both of these require standards in order to enable these capabilities. Currently many patients feel as if they do not have control over their health information and therefore are not engaged with it. Giving them greater control would foster greater engagement.

Another significant barrier to patient engagement is the belief on the part of many providers that patients do not wish to be engaged. In that respect this could be seen as the physician barrier to patient engagement. The conversations we've had surround the requirement to have 5% of patients 'message' their provider, which leads to discussions around workflow and guidance of how this can be done. Helping providers see how patient engagement will make their job easier as opposed to just making it more complicated would go a long way in overcoming this barrier.

7. Exchange

a. 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?

We are currently involved in a CMS pilot (Health Information Technology for Post Acute Care – HITPAC) to try and foster electronic exchange between a hospital and several nursing homes. We're still only in the pilot stage.

To my knowledge (and experience to date), there is little electronic transitions of care information being exchanged from SNFs and home health agencies. Most are still copying off their EHR or paper data and either sending of faxing the information. Interoperability is still a major issue because, in the LTC settings, most software vendors cannot produce or consume a CCD at this point in time. Some are working on it such as MDI Achieve (we are sitting on their development team). We hear from very reliable sources that Point Click Care is also working on this and has plans to have a CCD in place by years end but that is yet to be seen. I've heard that the major software vendor that supplies for assisted living (Eldermark) can produce/consume a CCD but has not achieved interoperability at this time. It seems that the HIE infrastructure is in place in Minnesota to exchange the information, and while a couple of the SNF EHR vendors are beginning development to allow for exchange, the progress is slow.

b. What actions have you taken or believe should be taken to overcome barriers to interoperability?

The barriers we see to interoperability are in two main areas: Limited financial resources among all SNFs, and limited understanding of database technology itself, or how to leverage EHRs to improve efficient and effective care. Many SNFs are still on paper. Those who do have EHRs are not using them optimally. Actions we are taking, as part of HITPAC, involve optimization efforts to improve the use of EHRs overall, and quality improvement efforts around workflows in transitions of care in both hospitals and LTPACs.

c. How can meaningful use program better enable HIE with other healthcare providers including SNF and HC?

Today, we don't see meaningful as the driving force behind interoperability. Perhaps as we get closer to 2014/2105 that will change. The LTPAC settings must see the business case for investing in their resources in order to be motivated to move their priorities. Certainly, the lack of incentives for the other settings has not helped the issue. At least one big EHR vendor seem to think that they have done what they need to at this time by providing view only access to SNFs. Of course, that is not true interoperability. Without the common denominator of an EHR and the financial and resource assistance of incentives and REC type support, they are left outside of the continuum of care. Closing the loop with expanded MU and REC assistance would help overcome this.

We would like to see LTPAC/SNF EHR vendors be certified in the same way that Hospital and Eligible Provider EHR systems are currently certified through the ONC HIT Certification Program. We would also like to see the same type of financial incentives that are currently part of Meaningful Use available for LTPACs and hospitals that demonstrate reduced preventable readmissions and adverse drug events as a result of interoperability and improved medication management at transitions of care.

Finally, Stage 3 & SNF, LTPAC, HH, BH information exchange: ask the experts (i.e. PT, OT, SLP, psychologists, counselors, nursing staff, providers) what they need to be able to most immediately care for a patient that is coming from acute care or a clinic. Keep the info short & sweet - using a CCD-like approach. Have a structure "reporting off" between caregivers that is verbal and uses the CCD-like tool as a roadmap for a verbal transition of care. There will always have to be opportunity to ask clarifying questions between knowledgeable professionals no matter how good the IT tool.

Given the above, I think an analysis is needed of the core information that needs to be shared across these types of service, and perhaps narrow down the requirements to a minimum. Also, I think ACOs will help give LTC/HC an incentive to invest in this capability. BH is more similar to clinics, so I think the best way to get them on board is of course to make BH providers eligible for incentives. Again, I think ACOs will help.

8. **LTPAC**

   a. **For Stage 3, to more directly address the interests of EPs focused on practice in LTPAC, Home Health and Behavioral Health; do you have suggestions for criteria appropriate for those care venues?**

      As SNF, home care, outpatient behavioral health providers, long term care providers and other groups who were not specifically included in MU need to communicate with providers who have been included in MU, the standards & vocabulary that are available in Stage 2-including new versions of HL7- need to be available & affordable to them right away.

      We cannot yet provide a list of data elements that should be included in an interoperable exchange yet. We are beginning to investigate the Interact 3.0 tools (http://interact2.net/tools_v3.aspx) for use in the CCD format, however we do not know what the final data set will be yet. We will probably end up recommending some combination of Interact 3.0 and data elements from other documentation sources, but again, this work is still underway as part of the HITPAC project. We were originally expecting it to be completed in September of 2013, however, now it looks like the project will be extended until Spring of 2014.

      Stage 3 criteria could include measures to demonstrate a reduction in preventable admissions and adverse drug events as a result of HIE/interoperability and medication reconciliations completed by pharmacists at all transitions of care. The ONC has taken up the challenge and thrown its support behind the HL7 Clinical Document Architecture (CDA) Continuity of Care Document (CCD), which has given EHR developers a means to approach interoperability. The work of ONC's Standards & Interoperability Framework is directly addressing the creation and widespread acceptance and implementation of transport, vocabulary and content exchange standards and mechanisms. A couple of examples of interoperability standards that come to mind are: 1) using standards such as LOINC (Logical Observation Identifiers Names and Codes) for ordering and reporting the results of clinical laboratory tests and SNOMED CT (Systematized Nomenclature of Medicine--Clinical Terms) for healthcare terminology. 2) automating the "pull" and "push" of cumulative patient-generated data into EHR and HIE platforms

9. **Vendors**

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

      Vendors are currently focused on implementation and upgrades of their systems in order to meet ever increasing meaningful use requirements. If vendors were to spend more time with smaller practices and critical access hospitals in helping them to redesign their workflow, observing what they do and helping them really think there workflow, it would serve two purposes: first it would help the practice optimize their use of the record and second it would allow vendors to develop a better product when they see how it is being used when they see which of their solutions work and which do not. We understand that this would be costly and difficult for vendors to do with geographically dispersed small clients.

Training: One of the shortcomings that we've seen with some vendors is the lack of easily accessible training support in digestible snippets (rather than hour+ long comprehensive training videos). Having well indexed, context sensitive snippets that could demonstrate specific pieces of functionality or workflows that fit in a busy daily schedule (for example a 3 minute video) would help ongoing education efforts. Most education occurs during the pre-go-live training sessions and seems to end there. The next phase is turning to the internal grapevine of information or relying solely on the one or two super-users.

Some of our clients have already learned that their vendor has "packaged" components within the certified modules that they do not need, including service packages that they may not need or want. While vendors maintain that components are interrelated & have multiple dependencies, the clients see costly combined components that they do not want. Some of these "packages" must be purchased by a certain date in order for the client to be on an implementation list. Also the maintenance agreements for all of the components within the certified module begin once the contract for the module is signed whether or not it is installed. It would help significantly if practices were able to only purchase what they need as the 2014 certification specifications suggested. In other words no hidden costs to end users in meeting the bare requirements of effective use.

Vendors could be more sensitive to the audit process their clients must go through and assist them with system-dated screenshots and other audit requirements.

Vendors could also improve the reporting mechanisms within their systems to assist providers with the multiple quality reporting requirements the client faces in addition to Meaningful Use. For example, user readable (but not "writeable") log files in the EHR that can prove elements requiring attestation have been met.

Reports that allow the provider to see the patient or opportunity that was missed for meeting functional criteria and doing well on quality measures.

Finally, for *effective* use, the ability for providers to be able to design and run their own queries via a simple interface which would allow multiple problems, multiple medications, lab results and allergies to be included in the query.

10. Audits

a. Should CMS take additional steps to provide EPs guidance on how to prepare for audit of meaningful use attestation?

Yes. The current method has been very vague and when started, the auditor was requiring documentation that was not required or recommended by ONC as guidance to REC's for their customers. It is my understanding that CMS was intentionally vague so as to not allow providers to game the system. This hurt the honest folks.

b. If so, what suggestions do you have as to what those steps should be?

There should be a user readable (but not "writeable") log file in the EHR which can prove elements requiring attestation.

We have been providing a pre-attestation and audit checklist for our customers that we have attached to this document in order to share with the committee as an example.

Finally, an official guide from CMS on what documentation is needed for each criterion would be a best-case scenario. It would also help if CMS would use 1-2 National Provider Calls to “walk” clients through a basic audit process and identify specific audit components and other evidence CMS considers essential to the process. Lacking that, we have been on a discovery path of what is needed based on client feedback during their audit experience. Organizations would appreciate clarity in what needs to be retained to successfully meet the audit documentation requirements. The perspective we’ve garnered on this topic is the “tell me what I need to do and I’ll do it” attitude.

In closing

Thank you very much for allowing us the opportunity to share our experience with you. We wish you luck in formulating your recommendations and would be happy to answer any additional questions you may have.

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