THEMES/QUESTIONS FOR PANEL 2

Responses provided by:
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1. **As you assess your readiness for stage 2, what objectives pose the greatest challenge?**

    a. Summary of Care/Transition of Care (10%) to be electronically provided.
        i. Lack of data standards
        ii. Provider and patent identification: lack a database of providers to determine which communication channel should be used.
        iii. Most SNF's & Home Care agencies don't have electronic systems to accept these electronically.

    b. Health Information Exchange (HIE):
        i. Lack of data standards: conflicting standards and approaches among exchange partners
        ii. Provider and patent identification:

    c. Changing Quality Measures, e.g. ICD-9 to ICD-10
        i. Short timeframe to make the ICD-10 changes and prepare for both vendors and providers.
        ii. Changes in Stage 1 measures require different reporting for EP's within the same EMR. Very challenging.

What **is your approach for addressing those challenges?**

a. Waiting for and scheduling the installation of the vendor system upgrade (due out in October, 2013). The PSHMC team must then review and determine the necessary workflow refinements and modifications.
b. Team is reviewing the Stage 2 requirements to prepare, but is largely dependent on the final vendor product.

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

    a. National standards
        i. States have latitude to address them which introduces variability for vendors and providers that cross state lines.
        ii. State HIE was requiring unique requirements of our vendor who refused due to the cost of variability. This would fall to the provider to make up the difference.

    b. State's readiness
        i. Defined standards
        ii. Defined timelines for readiness. Delays shorten provider's testing time.

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

    a. Objectives related to population management: if the federal government is moving to a new payment system, i.e. away from FFS (Fee For Service), then the objectives should align with "where we are going". Stage 3 objectives should reinforce the changes needed for the future.

    b. Objectives related to patient engagement: patient portal adoption and services/information that are important to the patients, e.g. discharge prescriptions, images, etc.

4. **What kinds of resources do you believe most important and useful for ONC and CMS to provide or to support so as to improve the ability of hospitals to effectively and economically achieve Stage 2 and 3?**

    a. Time…to design, build, test, implement, measure.
        i. Not enough time to do what is needed to successfully implement, especially as too much time is required to "interpret" the requirements
        ii. Vendors must interpret, design and build, then providers must implement, with newly defined or modified workflows, then test and measure.
            1. Note: Vendors are forced into selecting a specific workflow to certify, and we often find we must either ask for modifications to their reporting logic, OR completely change an existing (embedded) workflow. We're not opposed to changing workflow if it is a better workflow, but we are opposed to changing a workflow only to "prove" that we're meeting the intent of the requirement.
        iii. Vendor and provider resources are spread thin to complete all of this in the defined timeframe (especially with ICD-10 on the horizon, too!)
    b. Information / Clarity: provide greater clarity to reduce the amount of time by providers and vendors to "interpret".
        i. General objectives for Stage 3, i.e. where are going? This is needed to avoid major workflow and system modifications between stages. If the system can be built for both Stage 2 and 3, it eliminates or reduces this effort, even as standards for use or compliance are increased.
        ii. Specifics for Stage 2 and when ready, Stage 3. Provide clarification calls, communications, etc. for the rules/regulations as the requirements are not clearly understood.
        iii. Attestations and audits: provide clarity on this to reduce the anxiety and increase the participation in Stage 2 and 3. The systems and

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workflows must be built to meet the requirements AND collect the auditable data.

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

   a. Patient Portal adoption and use encouraged by Primary Care providers
   b. eVisit reimbursement to encourage physician use and adoption

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

a. Provider anxiety and liability concerns regarding sharing medical information that may be misunderstood by the patient or should NOT be shared directly with patients. There are no legal or other protections for providers when specific medical terms are shared with the Problem List or the CCD. Examples include:
   i. Morbid Obesity:
   ii. Bulimia / Anorexia Nervosa:

   Per a physician leader: *"There is an inherent barrier to utilizing this tool for effective patient engagement nonetheless. While complete transparency and timeliness of availability of information is important and useful to engage the patient as partners in their own care, providing all this on the portal may impair the utilization of the clinical record as a document for conveying impressions and plans among the diverse providers attempting to coordinate that care. The requirement to present a visit summary and other documents with all of the prescribed elements presents the information in a way that may be demotivating or even detrimental. Examples of this serve as the best explanation.*

   1.) A patient with an eating disorder such as anorexia nervosa or bulimia would be able to repeatedly analyze their weight and BMI which is actually detrimental to their treatment. In fact, each patient must sign a "contract" with their provider team as a condition of treatment agreeing not to weigh themselves or look at their weights. The required transparency becomes detrimental.

   2.) While it may be essential to convey to a referring primary care physician a diagnosis of depression with somatization and arrive at a collective approach to care, it may be equally important to put the focus elsewhere when describing the explanation of the physical symptoms with the patient.

   3.) A patient with morbid obesity caused by stress eating may be prone to even more over-consumption when reading a clinical note that is more

intended to convey a diagnosis than developing a supportive approach to chronic weight management.

So in conclusion:

1. *The frankness of an ICD 9 (or ICD 10) code can be counterproductive to engaging the patient in their care.*
2. *The patient record is a tool for licensed professionals to communicate in a language that is often not understood by all so that care can be planned and coordinated, and sharing that same information with the patient can actually be detrimental to engagement. "*

6. **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 and if so: What actions have you taken or believe should be taken to overcome barriers to interoperability?**

   a. No, PSHMC does not currently send/receive electronic transitions of care documents. The current process is handled manually by Care Coordinators who use the Release Of Information application from within the EMR to send the requested information via an electronic fax to either the SNF or HC agencies.

   b. Barriers to interoperability include:
      i. Lack of standards
      ii. Lack of readiness by SNF's, Home Care Agencies, etc. as they are not required to utilize electronic technology.
      iii. Complexity and redesign of our system and workflow process
      iv. Complexity of required data, e.g. Smoking status
         1. Too complex, not patient friendly, and too open for interpretation by patient, medical office assistant, clinician, etc.
         2. Simplify for greater data value and integrity
         3. Example: Required nomenclature:
            a. Current every day smoker
            b. Current some day smoker
            c. Former smoker
            d. Never smoker
            e. Smoker, current status unknown
            f. Unknown if ever smoked
            g. Heavy tobacco smoker
            h. Light tobacco smoker

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