



Meaningful Use: What is the Good and How Do We Leverage It?

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Modifications to EHR Incentive Program for 2014 MU Certification Hearing MU Stage 3 Listening Sessions

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2014 MU Stage 2 Attestations

	May 1	June 1
Eligible Hospitals	4	8
Eligible Professionals	50	447

- ▶ Medicare EPs attesting in 2011 = 58K
- ▶ % of these attesting for MU2 so far ~ **0.8%**
- ▶ Mostly individual EPs, not health systems
- ▶ Skewed towards those using a cloud-based solution
- ▶ CMS' major concern is functionality of 2014 ed. CEHRT

Modifications to EHR Incentive Program for 2014



MU Stage 2 Postponed Again for Some

Stage 1 OK in 2014 for Docs with Delayed CEHRT Availability

**DEPARTMENT OF HEALTH AND
HUMAN SERVICES**

**Centers for Medicare & Medicaid
Services**

42 CFR Part 495

[CMS-0052-P]

RIN 0938-AS30

Office of the Secretary

45 CFR Part 170

RIN 0991-AB97

**Medicare and Medicaid Programs;
Modifications to the Medicare and
Medicaid Electronic Health Record
Incentive Programs for 2014; and
Health Information Technology:
Revisions to the Certified EHR
Technology Definition**

Extension of Stage 2 MU for Those First Attesting in 2011 or 2012

1st Payment Year	Stage of Meaningful Use										
	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021
2011	1	1	1	1 or 2*	2	2	3	3	TBD	TBD	TBD
2012		1	1	1 or 2*	2	2	3	3	TBD	TBD	TBD
2013			1	1*	2	2	3	3	TBD	TBD	TBD
2014				1*	1	2	2	3	3	TBD	TBD
2015					1	1	2	2	3	3	TBD
2016						1	1	2	2	3	3
2017							1	1	2	2	3

*3-month quarter EHR reporting period for Medicare and continuous 90-day EHR reporting period (or 3 months at State option) for Medicaid EPs. All providers in their first year in 2014 use any continuous 90-day EHR reporting period.

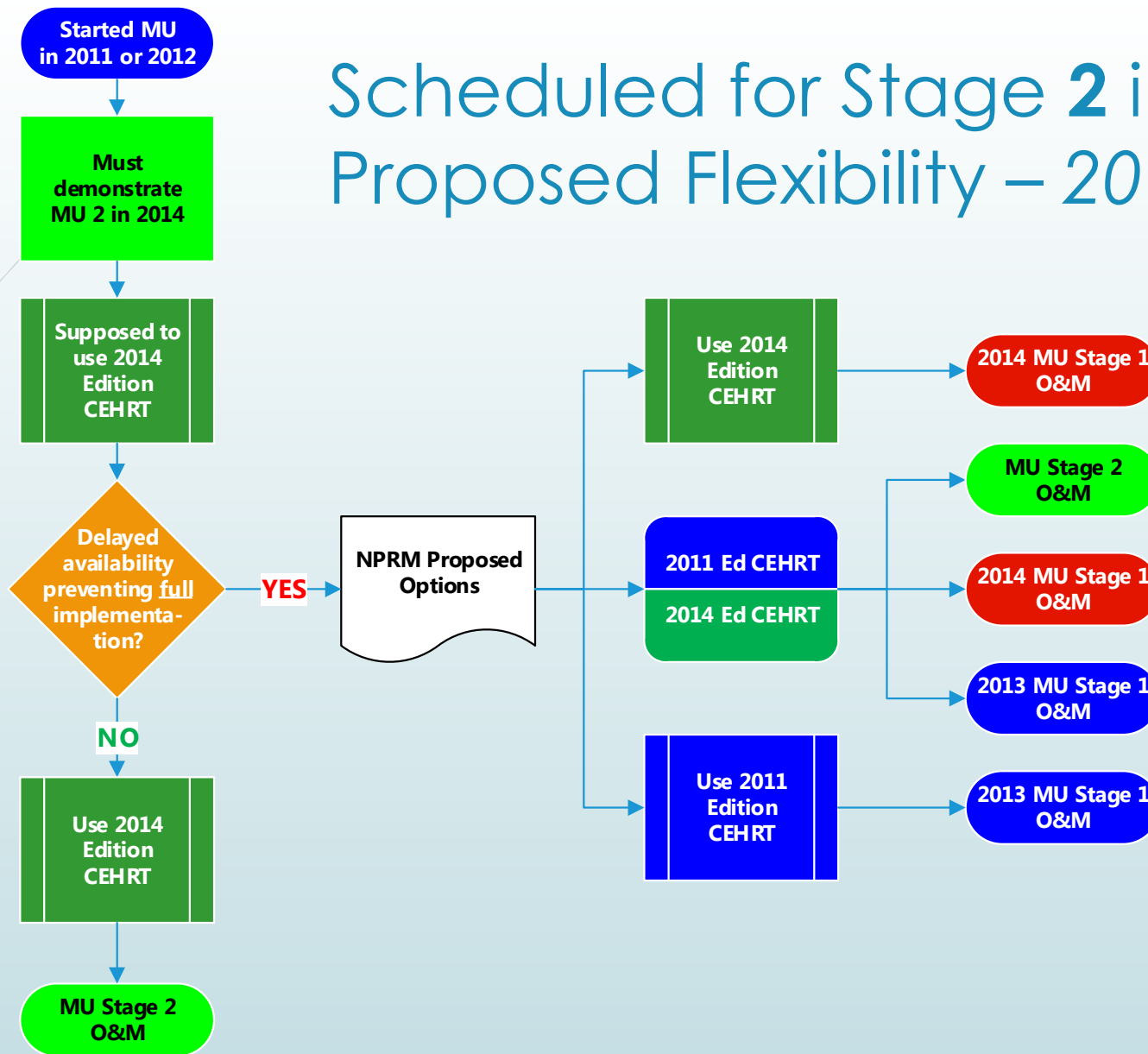
Translating this Table to...

TABLE 2—PROPOSED CEHRT SYSTEMS AVAILABLE FOR USE IN 2014

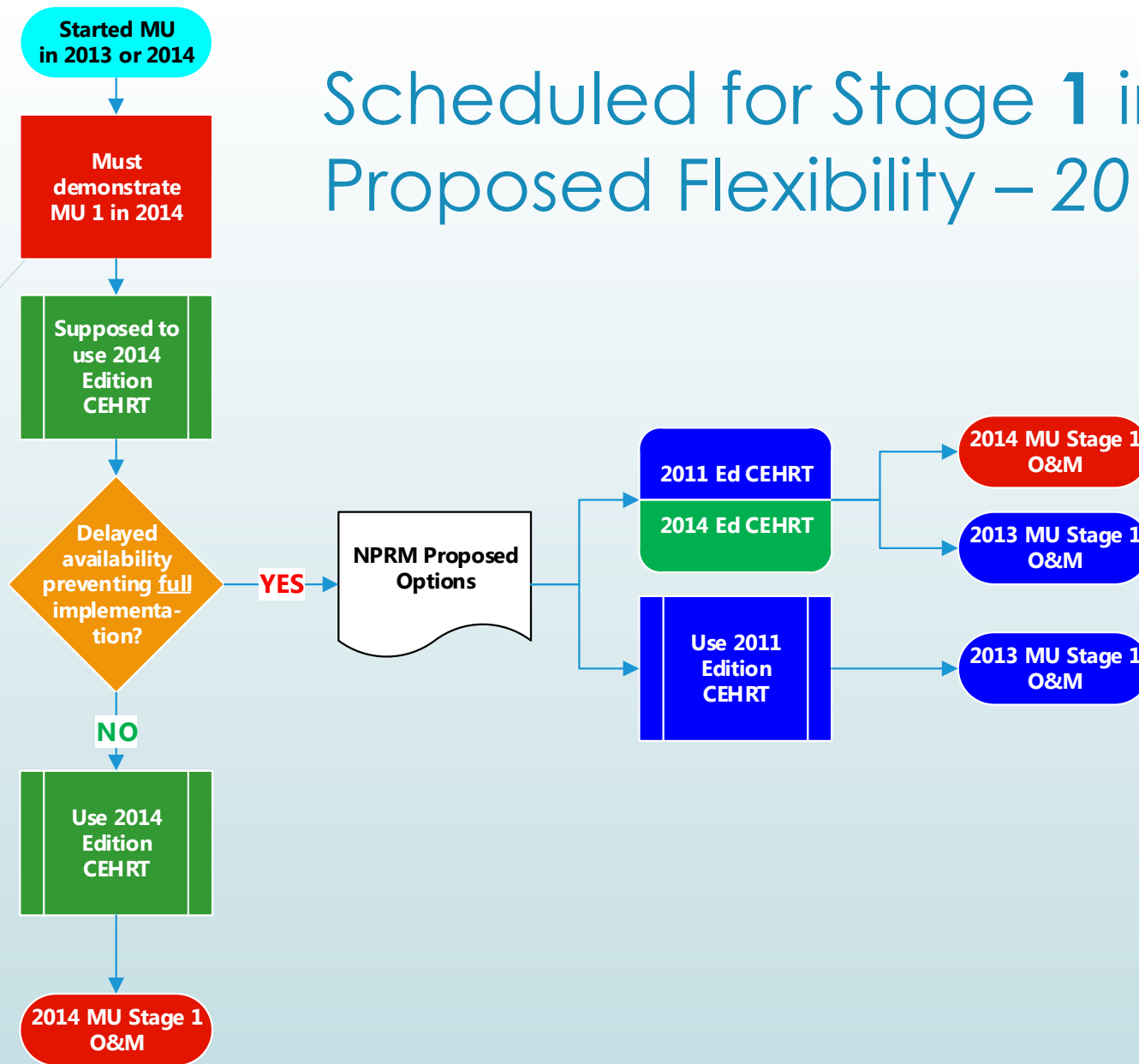
If you were scheduled to demonstrate:	You would be able to attest for Meaningful Use:		
	Using 2011 Edition CEHRT to do:	Using 2011 & 2014 Edition CEHRT to do:	Using 2014 Edition CEHRT to do:
Stage 1 in 2014	2013 Stage 1 objectives and measures*.	2013 Stage 1 objectives and measures*. -OR- 2014 Stage 1 objectives and measures*.	2014 Stage 1 objectives and measures
Stage 2 in 2014	2013 Stage 1 objectives and measures*.	2013 Stage 1 objectives and measures*. -OR- 2014 Stage 1 objectives and measures*. -OR- Stage 2 objectives and measures*.	2014 Stage 1 objectives and measures* -OR- Stage 2 objectives and measures*

* Only providers that could not fully implement 2014 Edition CEHRT for the reporting period in 2014 due to delays in 2014 Edition CEHRT availability.

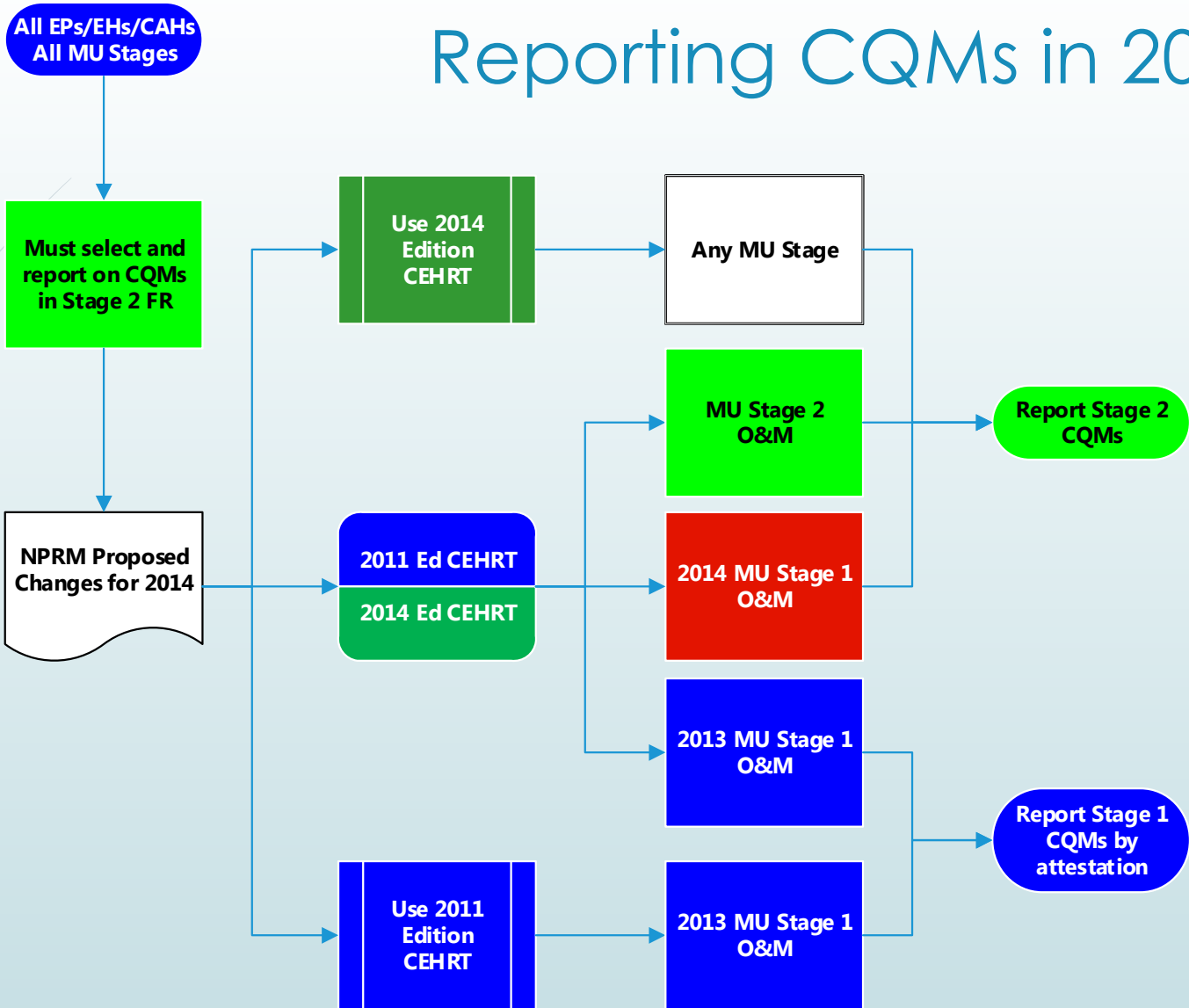
Scheduled for Stage 2 in 2014? Proposed Flexibility – 2014 Only



Scheduled for Stage 1 in 2014? Proposed Flexibility – 2014 Only



Reporting CQMs in 2014



AMDIS NPRM Response Considerations Additional Clarification Needed...

- Defining "...could not fully implement 2014 Edition CEHRT for the 2014 reporting year due to delays in 2014 Edition CEHRT availability"
- Stage 2 Duration vs. Stage 3 Start Date
 - No one has proven 2 years at a stage is enough
- Full Year vs. 3-Month Reporting in 2015

- CMS encouraging early comments



MU Certification Hearing (May 7-8)

- ▶ Feedback to ONC on EHR certification process
 - ▶ Benefits, challenges, suggestions
- ▶ Testimony to HIT PC Workgroup member reps
 - ▶ Certification/Adoption WG
 - ▶ Standards Implementation WG
 - ▶ Meaningful Use WG
- ▶ My context / role
 - ▶ ONC HITPC MU Workgroup (Apr 2013 –)
 - ▶ CCHIT Board (Jan 2014 –)
 - ▶ Hearing co-chair (w/ Paul Tang)

Panels and Perspectives

- Providers / HIE Organizations
 - Large hospitals, large & small practices, AHCs, IHS
- Vendors and self-developers
 - EHRA, Epic, Practice Fusion, SRSsoft, NextGen, Intermountain Health, Beth Israel Deaconess
- Certification / Accreditation Bodies
 - ICSA Labs, Drummond, InfoGard
- Private Sector representatives
 - CCHIT, DirectTrust, IHE, CommonWell, Healtheway

Benefits of an Ideal Program

- ▶ Helps drive large scale adoption of CEHRT, standards needed for functionality, safety
- ▶ Increases EHR purchaser & user confidence that
 - ▶ CEHRT will meet basic functional requirements
 - ▶ they can use the certified features as intended
- ▶ Robust platform for achieving quality goals

Challenges - Summary

- ▶ Insufficient time for product development, testing
- ▶ Concerns about certification include:
 - ▶ Criteria specificity locks in vendor-created inefficient provider workflows
 - ▶ Incompletely tested, unstable testing tools delay certification and create rework
 - ▶ Inconsistent interpretations among ATLS, ACBs, and auditors
 - ▶ Certification does not guarantee integrated product or interoperability
 - ▶ No clearinghouse for timely feedback and response
 - ▶ Time required for certification (or documenting certification) crowds out innovation

Presentation / Recommendations to HIT Policy Committee (May 8 → June 10)

- Reduce complexity of the overall program
- Align with other federal programs
- **Narrowly focus certification on the most important items**
 - **Interoperability, CQMs**, privacy & security
- **Use KAISEN process to improve program**
- Make stable testing materials available earlier
- Reducing the frequency (cost) of certification

HIT Policy Committee Action (June 10)

- Kaizen event – **passed** – recommend to ONC
- Limit scope of certification to interoperability, CQMs, privacy & security - **failed**
- Focus scope but allow other areas – passed but without super majority
- Tension between promoting needed functionality vs. limited certification scope
- Impact assessment needed

<http://www.healthit.gov/FACAS/calendar/2014/05/08/policy-certification-hearing-workgroup-discussion>

<http://www.healthit.gov/FACAS/calendar/2014/05/07/policy-certification-hearing>

http://www.healthit.gov/FACAS/sites/faca/files/HITPC_Certification_Hearing_2014-06-10.pdf

Maintaining the Trust While Decreasing Burden – Some Ideas

- ▶ Demonstration of stable functionality → trust
- ▶ Where CEHRT functionality is new or trust not yet established - **test**
- ▶ Where stable functionality demonstrated – **stop testing** (trusted functionality, deemed certification)
 - ▶ e.g., passed test in 2 consecutive CEHRT editions
- ▶ EP/EH feedback could prompt **re-test** requirement



MUWG Listening Sessions (May 20, 27)

- ▶ HITPC submitted its [stage 3 recommendations](#) to ONC in April 2014
- ▶ MUWG wanted to gather more input from EPs, EHs, Payers and Developers
- ▶ Share experiences in developing, adopting, and meaningfully using EHRs
- ▶ Focus on solutions that can be leveraged to achieve our goals while optimizing possible stage 3 requirements
- ▶ Four emphasis areas
 - ▶ CDS, Patient engagement, Care coordination, Pop Mgmt

Panels and Perspectives

- ▶ Eligible Professionals and a Patient
 - ▶ Solo, small group/PCMH, multi-specialty ambulatory group, multi-hospital system
- ▶ Eligible Hospitals
 - ▶ CAH, County HC, Children's hospital,
- ▶ HIT Support of Advanced Models of Care
 - ▶ Intel, NJ-HITEC, Joint Public Health Informatics Taskforce, National Partnership for Women & Families
- ▶ Vendors
 - ▶ EHRA, GE Healthcare IT, Siemens, athenahealth

Benefits

- ▶ Accelerated EHR adoption
- ▶ Chart data access - anytime, anywhere
- ▶ Patient safety
- ▶ Data visualization
- ▶ Data capture, sharing
- ▶ Public/Population health
- ▶ Patient engagement, portals
- ▶ Monitoring processes and outcomes
- ▶ CDS availability
- ▶ Tracking results
- ▶ Histories available

Challenges

- Too hard, too costly, diminishing incentives
- Some anxious, overwhelmed
 - PCPs driven out of practice, out of MU program
- Delays in getting, implementing 2014 CEHRT
- JAMA study did not show better quality from Stage 1
- TOC technology immature, business case lacking
- Measure definitions challenging to interpret
- Workflow optimization challenges

Challenges

- ▶ Stage 2 highway not yet built well enough
 - ▶ TOC challenges – HIE interpretations, readiness, reporting
 - ▶ Send/receive/consume CCDA SoCD documents
 - ▶ Readiness of other entities, rural areas for TOC, HIE
 - ▶ Vendors, organizations **NOT ready for Direct Messaging**
 - ▶ Spotty provider participation with HIEs
- ▶ Insufficient standardization
 - ▶ e.g., data transmission, semantic interoperability

Challenges

- ▶ Dysfunctional CQM reports
- ▶ Regulatory and usability issues
 - ▶ Checking all the little boxes
- ▶ Accountability for actions outside of our control
- ▶ Coaching sick IPs through portal registration, lack of direct control over use, portal "competition"
- ▶ Audit challenges
 - ▶ Different requirements and interpretations
- ▶ Paper requirements by some – repetitive work
- ▶ State Reportables – delays in readiness

Suggestions

- ▶ Much more focused and prioritized approach
- ▶ Focus on meaningful outcomes, not prescriptive use
- ▶ Evidence of use, not percentage (until mature)
- ▶ Improve CQM reporting logic clarity, consistency, ease of CQM reporting
 - ▶ Align e-CQMs across programs
- ▶ Improve portal interoperability consistency, harmonization (one patient, one portal)
- ▶ Portal usability without barriers
 - ▶ Literacy, languages, assistive device interoperability
 - ▶ PGHD: add Upload) to V/D/T

Suggestions

- ▶ **Emphasize more, better use of Stage 2 EHR capabilities over new functionalities**
- ▶ Clear, consistent specifications, guidance, and FAQs
 - ▶ **Single source of truth**, more effective **access** to FAQs
- ▶ 90-day or quarter reporting period for Stage 3, Year 1
- ▶ Extend the length of each MU stage to 3 years
- ▶ Expand capabilities for immunizations, reportable conditions
- ▶ Make reporting to registries easier

Questions and Comments

<http://www.healthit.gov/FACAS/calendar/2014/05/20/policy-meaningful-use-workgroup>
<http://www.healthit.gov/FACAS/calendar/2014/05/27/policy-meaningful-use-workgroup>