STATEMENT OF

THE AMERICAN COLLEGE OF PHYSICIANS TO THE NATIONAL COMMITTEE

ON VITAL AND HEALTH STATISTICS

EXECUTIVE SUBCOMMITTEE

Meaningful Use from the Practice Perspective

April 28, 2009

The American College of Physicians (ACP), representing over 126,000 internal medicine physicians and medical students, is pleased to have this opportunity to discuss the definition of "Meaningful EHR Use" with the National Committee on Vital and Heath Statistics (NCVHS) Executive Subcommittee today. The HITECH Act imposes an aggressive timeline on a massive project aimed at providing Electronic Health Records (EHRs) to all Americans. One early milestone is the required publication of a definition of meaningful use that will determine if doctors are to receive payments or suffer penalties related to their use of EHR technology.

We believe firmly that Health Information Technology (HIT) cannot, by itself, achieve any direct benefits for our healthcare system. If doctors and other healthcare providers do nothing more than replace their pens with keyboards, we will have spent an enormous amount of money and time without achieving the quality improvements and cost reductions many hope technology will provide. HIT does offer opportunities to improve healthcare delivery, but only if it is coupled with major changes in other areas such as care delivery, reimbursement, and acceptance of new responsibilities by all stakeholders including clinicians, payers, employers and patients. The process to define meaningful use presents a rare opportunity for us to encourage fundamental changes to our healthcare system and focus on what important changes are attainable through wide implementation of health information technology.

"Meaningful use" consists of:

- Use of certified EHR technology;
- Including e-prescribing;
- Demonstration that the EHR technology is connected to unspecified other systems so as to provide for the electronic exchange of health information to improve the quality of care, such as promoting care coordination;
- Submission of reports on performance of specified clinical quality measures and other measures using the EHR technology.

Many stakeholder groups are proposing that the definition of meaningful use must include new functions as essential parts of EHR systems. While much of what is being proposed can be seen

as appropriate and potentially achievable over time, there are significant impediments to the adoption and implementation of many of these ideas.

ACP has a number of specific suggestions and concerns regarding the EHR certification and the definition of meaningful use. These points fall into five broad categories: 1) Limitation of Time, 2) Certification Requirements, 3) Functionality for Practice, 4) Measurement of Meaningful Use, and 5) Finances.

Limitation of Time

If doctors are to have a chance to achieve the maximum incentive payment, they must be ready to begin demonstrating meaningful use by the end of 2011. This deadline does not provide time for new initiatives, new processes, or significant additions to functionality. Meaningful use has to be defined in a way that allows people to meet these requirements with reasonable effort – and if they do, the direct and indirect costs associated with that achievement must be accounted for in the incentive payments. We are concerned that any attempt to add requirements that are not already validated in practice and currently available in CCHIT-certified systems will result in our members missing the maximum payment in 2011. We cannot allow the pressure of time to cause us to skip necessary testing and validation of measures and functions.

Certification Requirements

Adding new, or more complex, requirements to EHR systems in order to achieve particular meaningful use runs the risk of raising significant barriers to EHR adoption – completely contrary to the goals of HITECH. While these functions may be technically feasible, they may not be feasible organizationally for most practices and hospitals. We should not promote them without extensive study and deliberation. Unfortunately, the HITECH Act only gives us a few months to sort this out.

Certification criteria must be based on existing HITSP specifications and CCHIT requirements. We do not have the time to add new specifications and new requirements and still have a sufficient number of EHR systems available for physicians to choose from and implement in time to meet the 2011 deadline. Vendor development cycle times are typically about 18 months. Pushing them to add functionality faster to meet ARRA deadlines could introduce usability and safety risks.

ACP is also concerned that adding new certification pathways, competing standards, and unproven technologies as some have proposed will pose unnecessary confusion and create risks to practices and patients – especially if there is a push to implement these new ideas within such a short period of time.

We should not go backwards to achieve initial use. All CCHIT-certified vendors will support CCD in time to meet the 2011 requirements. (The Continuity of Care Document is the ASTM and HL7 standard for medical summaries that has been recognized by the Secretary of HHS.) There is no reason to go back to older, less structured, or incomplete formats such as CCR. ACP supports the use of a single standard for medical summaries.

The certification requirements for 2011 must be achievable enough to encourage widespread adoption of health information technology that incorporates sufficient functionality now and lays the groundwork to assure that more robust levels of meaningful use can be achieved over time. Otherwise, HITECH will fail to achieve its goals. ACP recommends that EHR certification standards and requirements for demonstration of meaningful use can and should increase over time. NCVHS should consider calling for a six to 10 year pathway for achieving many of the functions currently advanced by some for 2011.

Functionality for Practice

Clinical relevance, especially with a focus on patient-centered care, must be the primary criterion for choosing to implement and use EHR functions While a particular function may seem to be a useful possible addition to an EHR system, there are several factors to consider before adding new required functions such as: a) the cost to build and implement the feature versus its potential value; b) the inefficiency and safety risks created when software is added without adequate integration; and c) usability in actual practice. More important to this program is how the use of the function will be demonstrated without adding burdensome requirements to physicians already frustrated with administrative burden and reporting requirements.

There may be cases where useful functionality can be better delivered through applications and services that are not part of a single all-encompassing application. For example, ACP has supported the use of auxiliary technologies such as population or disease registries, and patient portals as useful ways to support the PCMH. We are not suggesting that these auxiliary technologies are ready for inclusion in certification in 2011.

Certified HIT must be safe, secure, protective of patient privacy, and supportive of all relevant legal requirements for proper records management. In addition, all the HIT needs of a medical practice must be served by certified technology, not just requirements that are directly related to the definition of meaningful use. An EHR system that meets all of the meaningful use requirements but fails to provide the fundamental features every practice needs (such as maintaining a patient problem list, or linking to billing records) will be rejected by physicians and other clinicians in practice.

With regard to health information exchange (HIE), exchanges must ensure that common security functions are properly implemented. If data exchange is involved, the exchange partners must be willing and able to participate fully. We are concerned that some proposed exchange partners, such as state public health agencies, will not be able to manage their end of any data exchanges, leaving many practices without a feasible exchange partner.

ACP is concerned that requirements involving decision support will fail to address well-documented problems such as alert fatigue. For example, warnings of drug interactions are notoriously irrelevant. In addition, our members are concerned that their dismissal of alerts or other clinically inappropriate decision support prompts could be held against them in reporting and in medical malpractice allegations.

Test tracking is useful to improve the quality of care, but is not an efficient method for avoiding duplicative testing. The way to reduce duplicative testing is to intelligently incorporate HIE

(where interactions with other care providers can be queried), and to incorporate evidenced-based rules concerning the frequency and efficacy of testing. These are functions to which EHR systems and HIE should aspire – and be added to the road map suggested above.

Referral tracking is useful to reduce exposure and risk in certain situations - but a global requirement to track referrals is not justifiable or practical even in a technology-enabled practice. As an example, a doctor may generate four referrals during a visit – three of which are routine and not time-sensitive, one of which is urgent or semi-urgent. Meaningful use requirements should focus on tracking important referrals. Otherwise there is the risk of creating the unintended consequence of critical referrals getting lost as practices respond to a mandate to track all referrals. As with test tracking, it is HIE and CDS that may reduce unnecessary referrals - not referral tracking.

Measurement of Meaningful Use

The first question that must be asked regarding meaningful measures is, “Meaningful to whom?” Meaningful use must include data exchanges that are clinically meaningful and not "make work."

It is difficult to envision how "meaningful use" can be defined, promulgated, implemented, and measured by 2011 other than via data that practices create and can submit from their EHRs, including transmissions to pharmacies. While meaningful use should ultimately include important activities such as metrics for care coordination, referral/test tracking, and transitions in care, it is not feasible to design and validate these metrics for use in 2011. ACP recommends that these important measures of meaningful use be deferred for now but included in the proposed six to 10 year pathway.

ACP recommends starting a consensus-building process regarding the criteria that a definition of meaningful use should be:

- Linguistically clear
- Concise
- Evidence-based
- Valid and reliable over time
- Least burdensome and disruptive measurement option available
- Operationally defined (An operational definition identifies one or more specific observable conditions or events and then specifies how to measure that event.)
- Measurable with currently available measures
- Visibly linked to care quality (including safety) and efficiency (i.e. having face validity)
- Practical for small practices and hospitals
- Specifically, not dependent on the cooperation of information-exchange partners
- Protective of patient privacy

We are concerned that quality measures might be used inappropriately. Rather than measure meaningful use of HIT, it may seem expedient to select existing quality measures and existing measurement systems, such as PQRI, not because they are appropriate, but because they are available. While we support the move to EHR-based reporting as opposed to reporting solely

based on claims, we are concerned with how the data gets into the EHR so that it can be reported. If requirements are for reporting laboratory data from the EHR, but those data must be hand-keyed into the EHR, what would the measure demonstrate beyond the ability to type?

Reporting requirements must be varied to fit the necessary differences among practice types, medical specialties, and care settings. For example, not all practices manage Type 2 diabetics. Also, there should be multiple pathways for reporting, such as through intermediaries, to account for variations in practice. Keep in mind the differences and additional difficulties faced by groups such as rural and safety-net providers.

Possible targets for measuring meaningful use include:

- Reconciled problem lists;
- Reconciled medication lists;
- Allergy information updated at least annually;
- Prescriptions e-prescribed when appropriate and permitted
- Lab and imaging results received electronically;
- Tests ordered online (Ambulatory Computerized Provider Order Entry - ACPOE);

ACP supports e-health activities that enhance patient-physician collaboration and believes that all of these data (including test results, not just orders) should be available to the patients.

<u>Finances</u>
No amount of technology will overcome the disincentives of our dysfunctional payment system when it comes to improving our healthcare delivery system. Even if the HITECH Act provided sufficient incentives to cover the true costs of HIT, our physicians would still not be paid for performing the tasks that we all agree need to be performed. Technology can facilitate the work of care coordination, but the practice must also be reimbursed for the costs of providing the care coordination, not currently compensated. ACP believes that fundamental changes in the payment system must accompany the criteria for meaningful use or the project will produce the desired ends. We offer the following examples of changes in the payment system that would begin to move our system in the right direction.

- Build into the Medicare RBRVS system an add-on code for evaluation and management (E/M) services to identify that the E/M service was assisted by an EHR with clinical decision support tools designed to be interoperable. The add-on code would increase payment for the identified service by an amount that not only recognizes the investment of dollars and practice resources required to acquire and maintain such technologies but also the ongoing system-wide value to Medicare associated with use of such technologies

- Recognize and separately reimburse telephone and e-consults (structured email communication between patient and physician or other health care provider) that result in a distinctly identifiable medical service.

- Authorize Medicare payment of a “case management fee”, which would provide additional reimbursement per patient per month for physicians who agree to acquire and

utilize HIT with clinical decision support to coordinate care of patients with chronic illness.

- Exempt such additional reimbursement incentives from Medicare budget neutrality requirements. Because Medicare is likely to experience system-wide savings associated with an investment in HIT, creating on financial incentives to support the acquisition of such cost-saving technologies should not be subject to budget neutrality cuts.

Summary

In response to the question about what EHR capacities/functionalities are absolutely required to enable a safe, patient-centric, high-quality health care system that optimizes patient outcomes, ACP believes, in the context of the issues noted above, that key functions should include: a) the ability to generate condition or need-based registries; b) the ability to reconcile problem lists and medication lists; c) the ability to monitor common, nationally recognized quality indicators appropriate to the specialties practices and population served with options to view data at both the practice and individual clinician levels; d) the ability to generate customized clinical reports using simple query methods for specific indications (e.g., medication recall; identifying gaps in care); e) electronic prescribing with useful alerts; and f) clinical decision support that provides guidance tailored to the needs and preferences of the patient based on nationally accepted guidelines and protocols, but customizable at the clinician and practice level.

ACP is concerned that the proposed measures of meaningful use not exceed the capabilities of EHR products certified in 2009 by CCHIT for reasons explained above. Therefore, with respect to the critical EHR functionalities for which providers should be required to demonstrate use in order to earn an incentive as a "meaningful user" of certified EHR technology in 2011 we recommend the consensus-building process previously described to define meaningful use with a goal for initial metrics that leverage information and data accumulated through the normal workflow and use of an electronic health record. The list of possible targets to consider should include: a) reconciled problem lists; b) reconciled medication lists; c) prescriptions e-prescribed when appropriate and permitted; d) allergy information updated at least annually; e) lab and imaging results received electronically; and f) tests ordered online. These functionalities should be broadly applicable in ambulatory care across all specialties. Adequate metrics for hospital-based users of EHRs will need to include additional or different metrics based on comparable levels of complexity and importance.

ACP recommends that the road map for future years consider areas that begin to leverage health information exchange such as test and referral tracking as well as medication reconciliation and transitions of care across the health care system. As noted previously, ACP strongly recommends that new functionalities and measures of meaningful use be thoroughly validated before they are required.

In closing, ACP supports the objectives of HITECH and the payment incentives offered to stimulate adoption of health information technology. However, we have significant concerns that in the effort to leap forward into an HIT-enabled environment, that some proposed definitions of meaningful use and the certification process for EHRs will: a) marginalize existing standards and certification processes rather than using them as starting points to articulate a road

map for the future; b) be crafted without appropriate recognition of the potential negative impact on patients, practicing physicians and other health care providers; c) add unrealistic requirements for reporting which may result in additional burdens to our already stressed health care system. We must take this opportunity to significantly stimulate HIT adoption/implementation and place the United States on a logical, evidence-based pathway towards technology-enhanced quality improvement and resist the temptation to introduce untested standards, and new HIT functions. At this critical time, we cannot afford to underestimate the challenge of complying with new requirements which could lead to the unintended consequence of delayed adoption of HIT – or worse, enormous pressure to rapidly adopt technology that fails to deliver on the promise of improving health and bending the curve on health care costs.