Is Meaningful Use Certification Meaningful Enough for Your Medical Organization?

Seeking Criteria to Make EHRs "Meaningful" for Physicians and Patients

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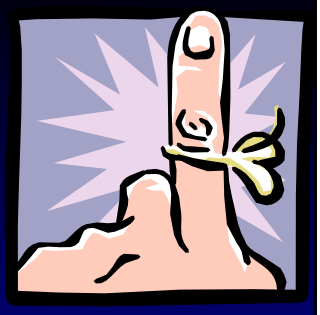


- This presentation is designed to provide accurate and authoritative information in regard to the subject matter covered. The information includes both reporting and *interpretation* of materials in various publications, as well as *interpretation* of policies of various organizations. This information is subject to individual *interpretation* and to *changes over time*
- Presenter has personal interests in consulting, presenting, writing about, and developing software in order to help physicians achieve compliant medical records and to help them facilitate quality patient care

Electronic Health Records *Needed* To Benefit Health Care!

- Despite the overwhelming hype,
- Is it possible to practice quality medical care WITHOUT an EHR?
- Is it possible to practice quality medical care WITH an EHR?
- Should EHRs
  - a) *dictate* care for patients?, or
  - b) help *physicians* determine care + report that care?

Evolution of the Current HIT Landscape

The Current Administration & EHRs

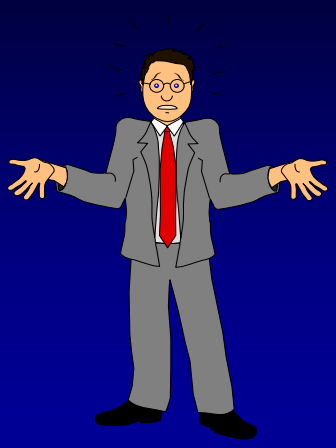
- In a major January 2009 Healthcare speech complementing his forthcoming economic stimulus package, President-elect Obama pledged to have all medical records electronic within 5 years

$$$ Incentives from ARRA & CMS

(Achieved IF, and only if, Prove "Meaningful Use")

2009 2015

Why Do We Need ARRA Incentives?



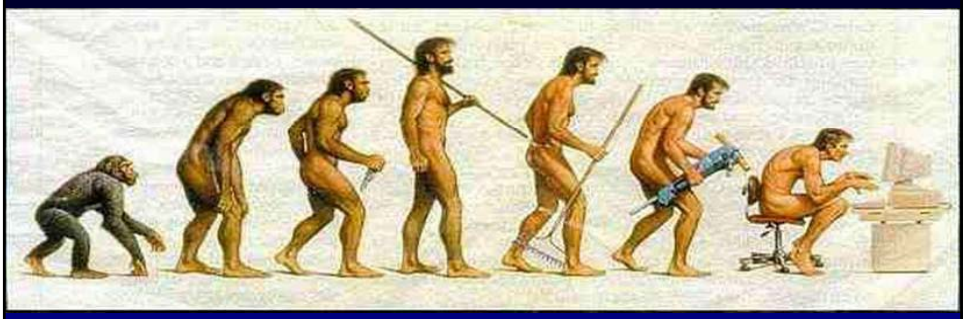
- Address what is *perceived* as physicians' primary obstacle to EHR purchase & adoption - **cost**
- Do ARRA incentive solve the economic challenge?
- What are physicians' other significant obstacles for EHR adoption & utilization?
  - Have these been addressed under ARRA & Meaningful Use?

ARRA Financial Incentives

- The Incentives:
  - $44,000 per physician (over 5 yrs) available for adoption and meaningful use of EHRs through Medicare
  - OR, $63,750 per physician available to qualified MDs through Medicaid
    - (≥30% of practice)
  - 2015: -1% CMS penalty (per year) for non-adoption
- Numb3rology:
  - $9,000 per year = $4.50 per hour = $36 per day = 1 additional 99213 per day
  - Annual maintenance cost of LAN type EHR + HIT support costs is ≥ $9,000 per annum
  - CMS 30% cut: approx –$45/hr. = –$360 per day
  - What is significance of 1% cut when already underpaying 75%?

However, receiving some subsidy > no subsidy

Meaningful Use Evolution



- 7/2009: 8 concepts, < 1 page
- 12/31/2009: 25 MU criteria, 692 pages
  - Proposed rule for MDs = 556 pp; standards for EHR Technology = 136 pp
- 7/13/2010: 20/25 MU criteria (15 core + 10 optional), 1,092 pages
  - Final rule for MDs = 864 pp; standards for EHR Technology = 228 pp

Two Categories of MU Challenges

Challenges from EHR functions defined by MU

Challenges from EHR functions that remain undefined by MU

Category #1: Challenges from Currently Defined MU Criteria

- MU criteria define WHAT must be done, but fail to describe WHO, WHEN, & HOW
- Misunderstanding about relation of EHRs to EBM
  - Potential for secondary use of EHR data to formulate care guidelines
  - Functionality of *properly* reporting performance measures
- Contaminating medical care with coding language
- Failure to distinguish between performance measures and quality care

Who, When, & How:

- Postulate #1: Software must *automatically* compile and submit valid reports on ALL MU criteria required for practice to receive ARRA incentive payments
  - Ideally, should provide practice with monthly status reports to ensure criteria are being met

Who, When, & How:

- Postulate #2: Satisfying MU criteria must complement patient care, not disrupt it, delay it, or prolong it
  - ARRA incentive = one 99213 visit per day; therefore fulfilling MU criteria should not require more time than one 99213 visit per day (7.5 mins.; & that equals the entire ARRA incentive)
  - Otherwise, the ARRA *incentives* will result in financial *disincentives*
    - *15 minutes extra work / day will COST $44,000 per MD;*
    - *one hour extra / day will cost >$300,000 over 5 years*

Reinforce Physicians' Priorities

>

- Success begins with the patient, the physician, and the EHR at the point of care
- Electronic H&P component of EHRs must work for physicians, or it won't work for the patients
- System must work for physicians and patients, or it won't work for the medical practice

Who, When, & How:

- Postulate #3: EHR designs should assign MU tasks & documentation to non-physicians whenever appropriate

MU Task Delegation (8/15 CM)

Measure:	Responsibility:
Core Measure #4: record demographics	administrative
CM #7: maintain medication allergy list	Nurse, med tech
CM #8: record vital signs	Nurse, med tech
CM #9: record smoking status	Nurse, med tech
CM #12: elect copy of record to patients	administrative
CM #13: clinical summary @ each visit	administrative
CM #14: **info exchange w designated entities**	administrative
CM #15: technical protection of PHI	Vendor

MU Tasks Delegation (4/10 MO)

Measure:	Responsibility:
Menu option #3: patient lists by condition	administrative
MO #4: patient reminders for care	administrative
MO #5: patient electronic access in 4 days	Vendor/ admin.
MO #7: medication reconciliation	Nurse, med tech

Who, When, & How:

- Postulate #4: EHR designs should integrate physicians' MU tasks and documentation into appropriate components of history and physical workflow

Integrating Physicians' MU Tasks (7/15 CM)

Measure:	Workflow:
CM #1,2,3: e-prescribing (record, med checks, and transmitting)	MDM: Rx
CM #5: maintain problem list*	MDM: Dx
CM #6: maintain medication list*	MDM: Rx
CM #10: clinical decision support*: a) treatment b) testing	MDM: a) Rx b) data ordered
CM #11: clinical *performance* measures*: a) treatment b) testing	MDM: a) Rx b) data ordered

Integrating Physicians' MU Tasks (6/10 MO)

Measure:	Workflow:
MO #1: formulary checks	MDM: Rx
MO #2: document lab tests in EHR	MDM: data reviewed
MO #6: identify & provide education materials to patients*	MDM: Dx, Rx, data ordered
MO #8: summary records with consults	MDM: Rx
MO #9, 10: electronic data to registries, public health organizations	MDM: Dx, Rx

Who, When, & How:

- Postulate #5: EHR functionality should *automatically* send appropriate information to designated agencies (e.g., patients, other providers, immunization registries, public health agencies)

Automating MU Information Sharing

(5/15 CM)

Measure:	Reports to:
CM #3: e-prescribing	pharmacy
CM #11: performance measures	CMS or state
CM #12, 13: patient summary/ visit summary	Patient
CM #14: patient summary	Other providers

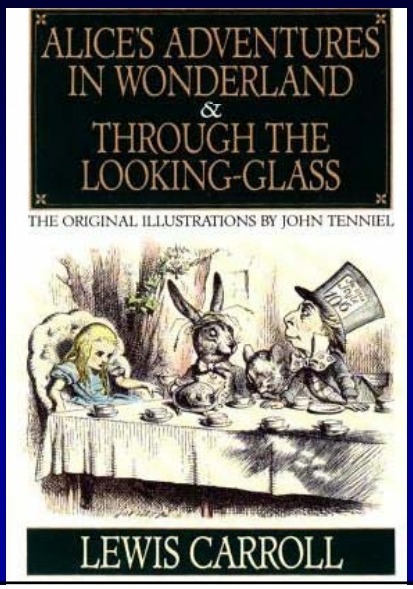
Automating MU Information Sharing

(6/10 MO)

Measure:	Reports to:
MO #4: reminders for follow-up care	Patients
MO #5: electronic access to health info	Patients
MO #6: patient education information	Patients
MO #8: summary of care record	Consultants
MO # 9, 10: public health data	Registries, public health

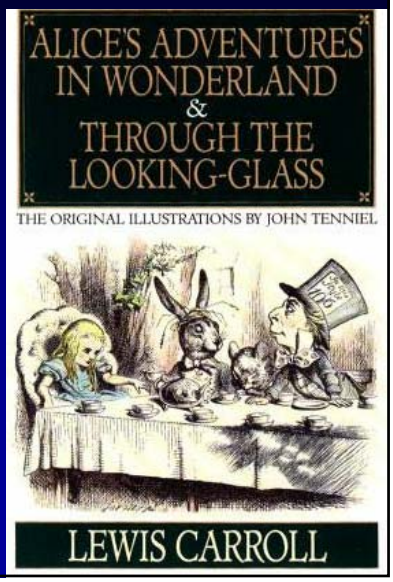
Questions About MU: Who, When, and How?

MU Evaluated Through the Looking Glass of Evidence Based Medicine



MU Evaluated Through the Looking Glass of Evidence Based Medicine

1) Is there EBM "*value*" in using EHR data for CER and/or to create guidelines and policy?
2) How should accepted care guidelines be *implemented* in EHRs to meet EBM standards?



Is there ***Value*** in Evidence Collected from EHRs?

EHR Data Collected

- Core Measure #11: Report "Quality Measures"
- Menu Option #3: "Lists of patients by specific conditions for quality improvement"
  - (e.g., CER)

EBM Hierarchy of Evidence

(Note: NO "meaningfulness" assigned to uncontrolled data from dissimilar EHRs)

Dilbert on Non-Controlled Data

How could/should EHR-collected data be used meaningfully?

Guideline Implementation Approaches & Evidence Based Medicine

EBM → CBM

EHR Utilization of Guidelines Under MU

- Core measure #10: Implement clinical decision support…with ability to track compliance
- Core measure #11: Report ambulatory clinical "Quality Measures" to CMS or the States

- ?What do these require to meet MU needs?
  - *Consider* the guidelines?
  - *Follow* the guidelines?
- {As presented, these measures usually interpreted as "must *implement* measures to satisfy MU requirements"; this approach takes us down the road → CBM}

EBM Utilization of Guidelines

- EBM is the integration of 1) clinical expertise, 2) patient values, and 3) the best evidence into the decision making process for patient care (Sackett D, 2002)

EBM Utilization of Guidelines

- "Good doctors use both individual clinical expertise and the best available external evidence, and neither alone is enough. Without current best external evidence, practice risks becoming rapidly out of date, to the detriment of patients Without clinical expertise, practice risks becoming ***tyrannized*** by external evidence, for even excellent external evidence may be inapplicable to or inappropriate for an individual patient."
  - David L. Sacket (1997), "Evidence Based Medicine," Seminars in Perinatology, Feb 21 1997, vol. 1: pages 3-5. http://www.ncbi.nlm.nih.gov/pubmed/9190027

Applying EBM to MU Guidelines

- In EBM, therefore, the critical factor is physician's **consideration** of a guideline and using judgment whether or NOT it should be followed in a given case
- CPT provides for this judgment with category II modifiers, which should therefore be incorporated into the decision process & coding
  - Inappropriately, CPT requires twice as much documentation effort to indicate a guideline was not followed as to indicate it was followed
- Optimal design calls for *equal effort* to indicate guideline followed or not; design provides for documentation of 1 of 5 choices:
  - ☐ Guideline considered & followed (maps to category II code)
  - ☐ Guideline considered & excluded due to medical reason (maps to 1P mod)
  - ☐ Guideline considered & excluded due to patient reason (maps to 2P mod)
  - ☐ Guideline considered & excluded due to system reason (maps to 3P mod)
  - ☐ Guideline considered & excluded due to non-specified reason (maps to 8P)

Dilbert's Analysis of P4P

Questions About MU & EBM?

Issues with Substitution of Coding Language for Natural Language

(proposed rule only, *for now*)

- Core measure #5: maintain problem list
  - "The measure associated with this objective requires that entries be recorded in "structured data" and in this context we adopted ICD-9 or SNOMED-CT® to provide that structure
- Physicians are not fluent in SNOMED or ICD-9, *nor should they be*
- Patients are not fluent in SNOMED or ICD-9, but CM #12 & #13 and MO #5 require provision of problem list to Pts.
- ***Coding systems should report a synopsis of documentation, not distort (or replace) that documentation***

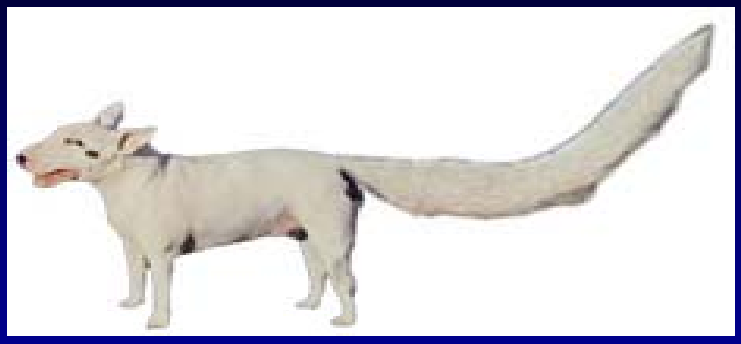
Issues with Substitution of Coding Language for Natural Language

CL ≠ NL

- 327.23 Obstructive Sleep Apnea
- 780.51 Insomnia with sleep apnea, unspecified
- 780.53 Hypersomnia with sleep apnea, unspecified
- 780.57 Unspecified sleep apnea

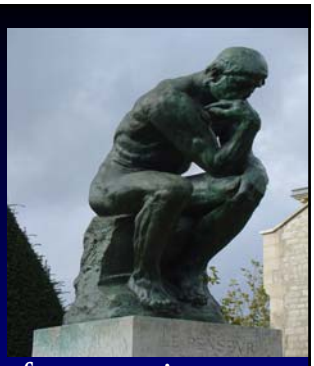
- "Probable obstructive sleep apnea, likely moderate to severe, possibly life-threatening; rule out paroxysmal nocturnal dyspnea"

We Must Avoid Having the Data Tail Wag the Quality Care Dog



{i.e., the process of codification should *report* the care, not *distort* the care}

Solution for CM #5



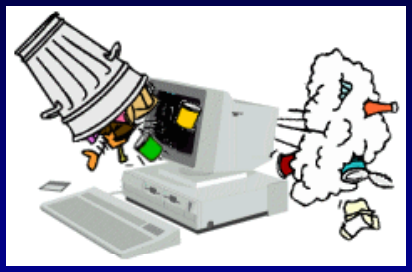
- Clinical uses of Problem List (& MDM section of E/M) ***require*** documentation in natural language
- If MU demands use of coding language for reporting purposes, then vendors must provide a *hidden* storage section for codified problem list, created by either:
  - Importing ICD-9 codes from PM system, or
  - Providing a natural language processing engine that *automatically* translates physician's problem list into SNOMED or ICD-9 language

Questions About CL vs. NL & EHR Functions Included in MU Criteria?

Bridging the Electronic Chasm:
EHR Functions Left Out of MU Criteria

AHIMA Physician Practice Council Response to MU Criteria

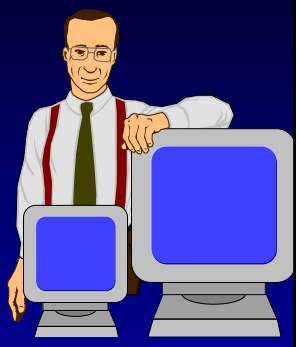
- ***"MU (criteria) do not encompass compliance or clinical competency or usability of the system"***



GIGO:

- We need to watch out for storm clouds that can obscure the sunny picture being painted for EHRs
- Our responsibility is to anticipate and understand the causes of potential problems, then chart a course to avoid them

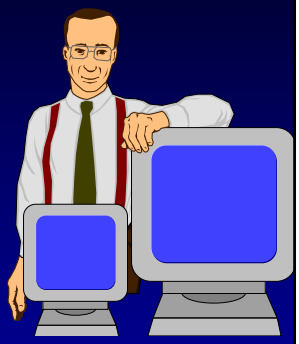
To Physicians, "EHR" Starts with the Medical History and Physical (H&P)



- "The EHR first has to work as a medical record"
  - Dr. Joseph Heyman, (at eHI's Connecting Communities Learning Forum, April 2006)
  - i.e., MUST have a compliant, usable, & efficient H&P that helps physicians promote quality care

Yet all 1,092 pages of MU include only *one sentence* about the H&P

- *Qualified EHR* defined as "an electronic record of health-related information on an individual that A) includes patient demographic and clinical health information, such as medical history and problem lists"; and B) has capacity to
  - provide clinical decision support
  - support physician order entry
  - capture and query information relevant to health care quality
  - exchange electronic health information with, and integrate such information from other sources"



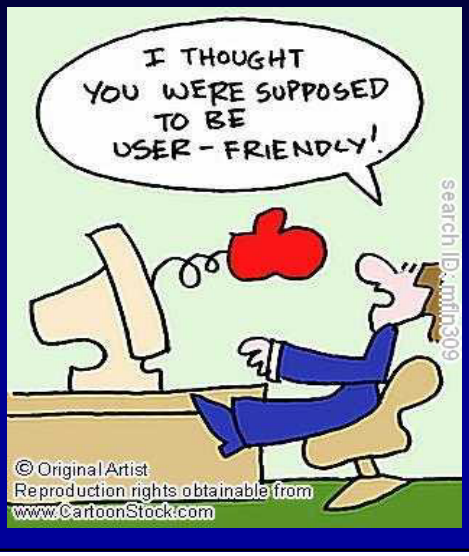
Physician Criteria for H&P Data Entry, in *ANY* Format

- Usability
- Efficiency
- Compliance
- Promote Quality Care **
- Data Integrity
- (Productivity)
- *Records with #1, 2, & 3 promote #4, 5, &6*
- ***However, none of these features has been addressed in MU***

What are Physicians' Obstacles for Successful EHR Utilization?

- "*Usability*":
  - Problems meeting physicians' criteria for an effective H&P
- Lack of documentation *Efficiency*
  - Sub-optimal screen designs
  - Inadequate data entry tools
- Failure to promote & ensure *E/M Compliance*
  - Not yet in the spotlight!
- Promoting the *Diagnostic Process*
- None of these is addressed in existing certification criteria

Overview of EHR Compliance Issues



Reports on Compliance Problems

- Most software coding engines fail to consider medical necessity, which CMS describes as "the overarching criterion for payment" (Medicare Claims Processing Manual, Chapter 12, section 30.6.1)
- Multiple articles indicate intrinsic non-compliance, particularly of "cloned" documentation, created by a variety of data entry functionality (eg, all lack ability for true HPI) (see "Documentation Bad Habits," Journal of AHIMA, June 2008):
  - Documentation by exception
  - Copy forward
  - Copy / paste
  - Pre-loaded generic macros
  - Generic pick lists

Conventional EHR Design & Compliance Risks

- *Note: EMRs have not solved E/M compliance challenges; see Part B News 5/1/06*
  - "The potential of such upcoding (by EMR software) has attracted the government's attention"
  - "EMR software…may lead them to 'select & bill for higher level E/M codes than medically reasonable & necessary"
- CCHIT certification fails to protect against these problems
  - Only 6 criteria for "operability" (eg, 'be able to record encounter')
- 2007 HHS & ONCHIT white paper: "These tools [defaults, templates, copying] can be extremely helpful if used correctly; however, the tools can also open the EHR-S up to *fraud or abuse*."

EHRs, Cloned Documents, & Medical Necessity

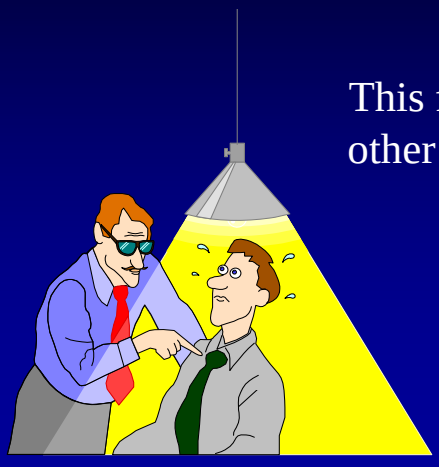
- "Cloned documentation does not meet medical necessity requirements for coverage of services rendered due to the lack of specific, individual information.
- All documentation in the medical record must be specific to the patient and her/his situation at the time of the encounter
- Cloning of documentation is considered a misrepresentation of the medical necessity requirement for coverage of services. Identification of this type of documentation will lead to denial of services for lack of medical necessity and recoupment of all overpayments made."
  - Eugene J. Winter, M.D., Medical Director for First Coast Service Options, Inc.
  - http://www.alliance1.org/conferences/National2008/materials/medicaid/Medicare_Document.pdf

"The Perfect Storm" Federal Audits of Practices with EHRs

- *Medical Economics*, April 09
  - 4 practices audited after implementing EHRs and using them as instructed and intended
  - Audit failures ranged from 20% to 95% of charts
  - Fines ranged from $50,000 to $175,000+ per physician
  - Non-compliant documentation is also a "canary in the coal mine" for data integrity and quality of care

Questions About EHR Functions Left Out of MU Criteria?

"Meaningful Use" (for ARRA incentives) is Putting ALL the Heat on Practices & Physicians



This focus overlooks the other half of the equation!

Question #1

- Could you "meaningfully" drive an old auto lacking brakes, steering, and an effective engine on I-95????
  - (Even if it has a "certified" GPS and a 4G I-Phone to *meaningfully* report all its problems)

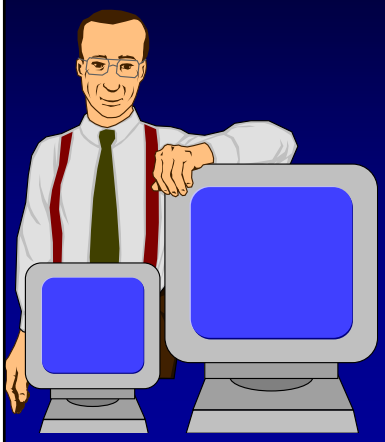
Question #2

- Is there any reason that a superb electronic data storage / retrieve and information sharing system should not ALSO provide superb data entry features that meet physicians' H&P needs and ensure "Quality In → Quality Out"?

E/M Compliance is a Key for Effective H&P Design

- E/M is a codification of the comprehensive H&P physicians learn for optimal care ("Bates Guide to Exam & Medical History")
- E/M compliance-based EHR designs align with physicians' optimal workflow & quality care processes
- Meeting compliance needs also provides audit protection, provides liability protection, and increases productivity (for MDs not currently over-coding)

Integrating Designs for Compliance, Usability, and Efficiency into the EHR



- To ensure quality diagnostic decision support and physician satisfaction, practices (not vendors) ***must*** take control of their electronic transformation process!
- This includes an effective transition team, H&P criteria, H&P benchmarks, customization, and verification before implementation

Sample Physicians' Benchmarks for EHR System Capabilities

- *Compliance*: When used as designed, system guides compliant documentation for every visit, including consideration of medical necessity
- *Usability*: Permits data entry by writing, dictation, and keyboard; follows physicians' diagnostic process (i.e., optimal workflow)
- *Efficiency*: must facilitate completion of care and E/M compliant documentation of a comprehensive new patient visit (medically indicated) in not more than _____ minutes of physician time

Sample Physicians' Benchmarks for EHR System Capabilities

- *Quality*: Documentation prompts that guide level of care appropriate for nature of presenting problem
- *Data integrity*: Another MD (or an attorney) can review a record & find it to be appropriate for the patient, and to make medical sense
  - Requires entry of *individualized* narrative documentation, with absence of pre-loaded clinical information

Sample Physicians' Benchmarks for EHR System Capabilities

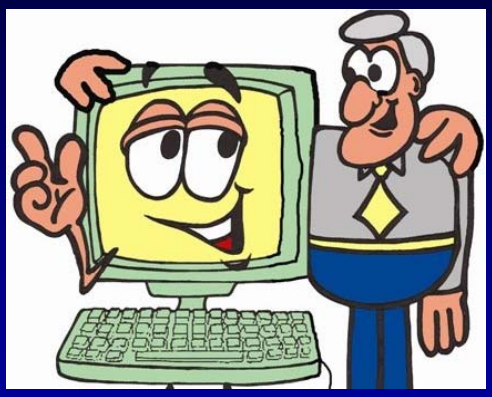
- *Productivity*: no decrease in practice productivity following EHR implementation
- *Training*: physician time for customization and full training in effective use of H&P requires < ____ hours
- *Transformation*: confirm success ***prior*** to implementation / purchase?

HITr Truisms

- "Successful transformation is 1/3 technology and 2/3 people"
  - (Dr. Carolyn Clancy, director of AHRQ; Sept 27, 2006)
- "The electronic health record is a sophisticated tool whose design and functionality must be directed to helping physicians practice the best patient care possible. The EHR must supplement physicians' knowledge and judgment, not supplant them through automatic insertion of pre-programmed clinical information and/or automated decisions for patient care"
  - *(SRL, Practical EHR)*

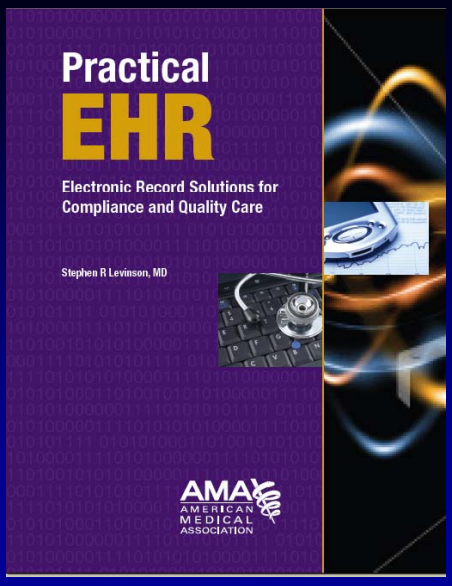
We Need to Re-Focus Our "Meaningful" Concept to Include

- Meaningful Use of
- Meaningful EHRs
- Certified by Meaningful Criteria



thank you for participating

Final Questions?



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