NATIONAL COMMITTEE ON VITAL AND HEALTH STATISTICS (NCVHS)

Executive Subcommittee

Hearing on "Meaningful Use"

Panel 6: The 'Glide Path' to Meaningful Use for 2011 and Beyond for Providers

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Good afternoon. I am Dr. Jonathan Perlin, President-Clinical Services and Chief Medical Officer for Nashville, Tennessee-based HCA. I bring the perspective of a system that operates 166 hospitals, over 200 ambulatory care centers providing surgical, cancer and imaging services and more than 380 physician-practices. We provide between approximately 5 percent of major hospital procedures nationally, provide about 6 million Emergency Department visits (including over 1 million uncompensated visits), and have over 185,000 employees, including more than 60,000 nurses.

While we have over 1,500 employed physicians, more than 80,000 credentialed physicians comprise our voluntary hospital staff. We are in the early stages of moving from a basic electronic record/hospital-information system to a system providing advanced clinical functions, including computerized provider order entry (CPOE) and interactive decision support. The HITECH Act of the Economic Stimulus legislation has unequivocally accelerated our migration, and I would like to share our thinking on the concept of meaningful use.

I would also note that my perspective is informed by the privilege of having spent nearly a decade in the Veterans Health Administration working with colleagues in my successive roles as Chief Quality Officer, Acting Chief Research Officer, Deputy Under Secretary and, ultimately, as Under Secretary for Health (the Chief Executive Officer) successfully implementing electronic health records across that system. The results, as validated in the academic literature and lay press, were unmatched advances in safety, quality, and efficiency. In short, electronic health records improved the value – the relationship of quality outputs to resource inputs – of health care, the ultimate objective of the HITECH Act.

What do providers see as the critical EHR functionalities to enable a safe, patient-centric, high-quality health care system that optimizes patient outcomes?

The critical EHR functions enabling safe, patient-centric, high-quality health care are enunciated with remarkable consistency among researchers and practitioners. They support the primary axiom of medicine "first do no harm" and secondarily to inform the care that might be provided. Thus, almost all lists of core functionality start with the ability to provide knowledge of allergies and medications. The next level of functionality is a "problem list" that includes

past diagnoses, and then adds laboratory data and more detailed treatment records. Sometimes, the aggregate of these features is referred to as a continuity of care record or document. It is the sort of "patient brief" that can easily be transported across health information exchanges, even before true interoperability is available at the level of granular data.

What are the critical success factors needed for robust participation in the incentive programs by eligible professionals in 2011? By hospitals? What factors would promote continued participation in later years?

What are provider perspectives on potential barriers to health IT adoption and what are their major concerns? What education and tools could mitigate them?

The number of hospitals eligible to participate in the incentive framework in 2011 will largely depend on how high the bar is set in defining the functionalities required for "meaningful use" and the level of connectivity required to demonstrate "health information exchange." I'd like to comment on three critical factors for attracting robust participation in the incentive program:

- First, it is imperative that we provide clear guidance on the desired outcomes at the end of a defined period. We emphatically agree with Dr. David Blumenthal's recent *New England Journal of Medicine* editorial in which he argued that the point of Health IT (HIT) was improving healthcare and value. Thus, the desired outcomes of "meaningful use" must transcend technical specifications and include guidance addressing the improvements in safety and quality that are intended.

  We, again, agree with Dr. Blumenthal that Health IT is a means, not an end: Health IT alone is not sufficient to transform our health system into one that provides the right care in the right place at the right time for every patient. HIT is a tool for optimizing care processes that have been designed to be safe, patient-centered and promote high quality care. Automating bad care processes will not create a high-performing health system. The health IT community has its "feet to the fire" now to show in the next few years that HIT can significantly improve cost, quality and efficiency. If we view HIT as an end in itself, independent of focusing on improving care processes, we will fail to realize the full value of these functionalities.

- Second, it is rational that we build on what currently exists. We should build on both existing quality programs (the Hospital Quality Alliance and the Physician Quality Reporting Initiative) as well as existing data standards, framing the outcomes in terms of both technical specifications of "use" and measures of health care improvement.

- Third, we recommend progressively escalating incentive requirements over time. As the companion article by Jha *et. al.* noted, only 1.5% of hospitals (excluding the Veterans Health

Administration) currently meet a definition of even modestly using electronic health records with advanced clinical features, such as interactive decision-support. A number of formidable issues underlie this anemic utilization rate:

- To date, system implementation is expensive in terms of capital acquisition and potential operating losses from disruption of hospital and physician practices. We are encouraged that the incentive program will foster innovation in terms of both cost and usability, but in the interim, the requirements to increase utilization by physicians, in particular, require "up-front," even speculative investment to avoid the 2015 penalties and changing an ingrained culture. Even with full commitment, implementation in complex hospital and system environments is a multi-year endeavor. We are encouraged that the incentive program will foster innovation in terms of both cost and usability, supporting the required culture change.

- In terms of technical specifications, a flexible, staged approach to defining "meaningful use" should be utilized to allow for industry innovation over time. Well-developed, widely deployed technology exists today to view and exchange labs, imaging and pharmacy data making these three functionalities a logical starting point for "meaningful use." Given the differences in communities, populations and facilities across the country, a flexible approach to building functionality, not simply requiring a massive EHR for every hospital, will allow for the technology to best meet the needs of the provider and the patients they care for.

- Beyond the hardware and software challenges, we have a "warm-ware" or human challenge: Clinicians have not embraced the information revolution with the fervor of other industries. While this derives, in part, from "unfriendly" software, with impenetrable user interfaces, and while we appreciate the motivation that both the positive and negative incentives provide, as it is said, nine women cannot make a baby in a month: We have to achieve a culture change, and that is an end, not a starting, point.

  Providers are anxious to see the full field of play. There are serious concerns, given the short timeline to the first payment year in FY 2011, that vendors will not have the capacity to support the onslaught of providers attempting to implement systems in the next year and a half.

There are important factors that would be relevant to continued participation in the later years of the incentive program and beyond. It is imperative that the incentives enunciated at the outset not be diminished during the duration of the program. Not only would this undermine the intended activity, but it would render any future incentive program without credibility. Additionally, the penalty phase beginning in FY 2015 will provide an incentive not only for continued participation by the earlier adopters but could serve as the tipping point for late adopters to become meaningful users.

Are there specific anticipated impacts on small providers? Rural providers? Providers with significant Medicaid populations? Early adopters?

The tide of the incentive program must raise all ships. Exclusions of classes of providers will magnify disadvantages of the populations they serve. Functionality without *information exchange* will not "transform" the system. The greatest value added will be in the ability to make the data flow by creating an interoperable Health IT architecture. The meaningful use, quality reporting and information exchange components of being a "meaningful user" are all connected. Outside of the nascent and limited "network" provided through the NHIN trials and RHIOs, we're still struggling to make health information exchange operational on a national scale. In short, as we build the equivalent of the personal computer revolution for hospitals and doctors' offices (and patient homes), the government needs to foster building the "web" that makes the "internet" revolution possible.

With respect to administration of the incentives, it would be rational that early adopters not be penalized for early investment, or fair that largesse disproportionately accrues to late "free-riders."

In closing, it seems advisable that eligibility for incentive payments requires that Health IT systems are not only installed by providers, but that they are really used by clinicians. Full implementation of HIT will require critical changes in culture and workflow to ensure that clinicians are using the technology in a meaningful way. This will be a collective learning experience, and all will benefit from best practices and lessons learned about successful implementation strategies in the early stages. As well, we hope that there may be technology innovations, like scalable application service provider (or "software-as-a-service") models that can support complex physician practices, and even hospitals.

It would be beneficial to have clear articulation of 5-year goals defining both technical use requirements and population health service outcomes. That "meaningful use" would involve practitioners increasingly utilizing interoperable health information technology to generate clinical action and inform those with patients' clinical histories would suggest progressive requirements for computerized physician (or other provider) order entry and connection to a qualified health information exchange as two central tests. We strongly support a definition of "meaningful use" that assures meaningful change. Given the height of the hurdle financially, functionally, and culturally, breaking the goals into achievable steps – that recognize walking as a prerequisite to running – would prove helpful.

Thank you for the opportunity to provide input. We look forward to working with you to achieve the intended benefits of HITECH for all Americans.