# Medical Strategic Planning, Inc.

*DEFINITIVE ANALYSIS OF EMERGING MEDICAL DEVICE & INFORMATION SYSTEMS MARKETS – WORLDWIDE™*


April 29, 2009

Marjorie S. Greenberg

Executive Secretary, NCBHS

Center for Health Statistics, Centers for Disease Control and Prevention,

3311 Toledo Rd., Room 2402, Hyattsville, MD 20782

Re: National Committee on Vital and Health Statistics, Executive Subcommittee hearings – April 28-29, 2009

Dear Secretary Greenberg,

Thank you for the opportunity to submit this written testimony for the subcommittee's consideration. We would first point out our ability to help you determine the impact on EMR developers of any 'meaningful use' criteria set.

Medical Strategic Planning (MSP) would like to inform the subcommittee of its extensive data on EMR system functionality. In cooperation with Bill Andrew, MSP has conducted EMR system functionality benchmarks since 1994, the most recent (13$^{h}$) iteration of which was participated in by 104 EMR developers and netted over 220,000 assertions about their products functionality, including various quality measures, IOM, HL7, HIPAA and other standards to mention but a few of the 2,200 attributes per EMR developer catalogued.

We also would inform the subcommittee of more limited information we have cataloged on 43 EMR developers on our MSP EHR Selector™, a web-based resource we develop and enhance in collaborate with Dr. Caroline Samuels, M.D. The EMR Selector is available to partners including members of HIMSS, MGMA, ACC, ACP, AGA, AHQA and other CIOs, EMR consultants and individual physicians. It has data on 400 functional characteristics for each of these 43 vendors and is currently being expanded.

These two databases form a rich repository of EMR functionality against which candidate "meaningful use" (MU) criteria can be evaluated to determine how various MU criteria would include or exclude various EMR developers' ability to comply and remain in the U.S. EMR market; for the criteria you set will become a bar that must be passed to remain a viable competitor. If that bar is set too high, the ARRA will be anything but revival for EMR workers in these firms. Of course, until the specific MU functional requirements are known, we can't determine whether or not they are available in either of our two databases.

If the committee was willing to work with us proactively on a confidential basis, we could model the impact of various criteria (if they already exist in the databases) or include them as 'candidate' meaningful use criteria in updates to the MSP EHR Selector, for the purpose of collecting this information from our participating 43 vendors or simply run an analysis if the criteria are already included. Responses from our EMR developers currently on the EHR Selector website is generally quick, and the developers there represent over 75% of all active EMR licenses in the U.S. physician office space. Perhaps this could expedite your analysis phase.

If you need a broader sample, we have more EMR developers participating in our annual EMR Benchmarks than belong to the HIMSS EHRVA, and they include EMR developers that specialize in the smaller medical specialties that have not yet adopted EMRs. That is why MSP could deliver a better response than other organizations such as the HIMSS EHRVA group, which is clearly biased to the larger healthcare I.T. companies.

We could also include 'candidate meaningful use' criteria in our 2009 MSP/Andrew EMR Benchmark, now being prepared. It will launch this summer, but takes vendors about 5 weeks to complete, so it might not be done in time for your deadlines. The advantage however is that it would draw responses from a broader cross-section of vendors. In total, 104 EMR developers responded to the last benchmark out of the 161 EMR companies MSP invited. The 2009 benchmark will invite 230 EMR developers, so it is possible that participation might increase, yielding more data for your use. We would be happy to work with the subcommittee to determine what possible criteria could be included. In order to get a better response, we could make EMR developers aware the information was being collected for the subcommittee.

Second, regarding requirements for 'meaningful use', we offer the following perspective. Meaningful use for whom? We believe that question is paramount. We suggest that the 'who' is physicians first, and patients second, and other EMR stakeholders third. Four years ago Dr. Brailer cited data indicating that 50% of EMRs deployed ultimately failed to meet the user's expectations. More recent work by the MRI indicated the number was now 20%. Studies recently published indicated the primary reasons for failure were: difficulty using EMRs and slow downs in office workflow after they were deployed. We think therefore that all 'meaningful use' criteria must be evaluated against the impact they will have on physicians, and how they conduct daily office workflow. In many ways, that is NOT in conflict with the ultimate goals of other EMR stakeholders. Physicians want to reduce Rx errors, want to improve quality, want to have point-of-care, decision support and would welcome technology that makes care faster.

This last point is critical, particularly if Obama is serious about making health insurance available to 46M new Americans. The coverage will be meaningless UNLESS there are group practices with the capacity to accept these newly insured Americans into their practices, and that means that EMRs that ENHANCE workflow are critical to creating the extra care minutes required each day to accept these new patients into their practices, many of which are now CLOSED to new patients. That means seeing 45-50 patients a day, not 30-35. **Enhancing workflow efficiency is a MUST 'meaningful use' criteria**.

In order to enhance workflow overall, the issue of how EMR integrates with CPM (computer practice management) is relevant, because much of total office workflow depends on coordinated capabilities of both computer systems. Indeed, many practices choosing an EMR today on our MSP EHR Selector™ website are looking for either one that is totally integrated with CPM already or at least has a viable interface to the CPM they currently have deployed. Workflow is enhanced when eligibility is verified, formularies loaded into the EMR, patient preferred pharmacies are loaded, reminders are sent so that patients show up at scheduled times, and E&M levels of the visit are sent back to the CPM. **Encouraging the adoption of EMRs that ignore CPM connectivity would be short-sighted, no matter what other MU criteria they met.** This was not discussed at all during the first day of the hearings. By the way, we track interfaces to about 20 of the largest CPM systems for each of the 43 EMR developers on the MSP EHR Selector, so we could help you there also.

Some EMRs are built on user-accessible workflow (or information flow) 'engines'. This means that in addition to the physician being able to change the EMR's basic workflow for different patient encounter types, the EMR is aware of the following items: 1) who the patient is, 2) what the encounter will be (annual physical, whatever), 3) who is staffing the office that day and what their patient care 'roles' are, 4) where each provider is working. With such information, the user is not subjected to "pulling needed templates out of the EMR", rather the EMR can proactively PUSH data organized by patient, encounter, problem list and diagnosis (in the case of chronic disease) to the various caregivers – greatly reducing non-productive time for them to navigate the menu structure of whatever EMR they are working with. Such systems provide user-accessible workflow automation, yet none of the larger EMR developers that testified mentioned any of this, because none of their systems support it. Your selection of EMR developers did not represent a broad cross-section of the EMR market, nor does it cover all of the 39 different practice specialties that EMRs must automate for national priorities to be achieved. We could have provided (and would be willing to do so) a better list of vendors that do represent the broader medical specialties you are looking to automate and create 'meaningful use' requirements for.

If practice workflow enhancement is to be a MU criteria, then this becomes an important function. If you only look at the bigger vendors or you allow the subcommittee to be stampeded by companies like GE, Allscripts, McKesson, Cerner, etc. then you may well set criteria that drive more specialized EMR developers out of the market, including those whose systems are more workflow efficient, because they may not meet other MU criteria you set. You will also greatly increase the cost of deploying EMR solutions, because the vendors you are allowing to remain are among the most expensive EMR products on the market and are far too complex for most 1-6 physician practices, which by the way are the very ones who have not yet adopted, but will under the ARRA stimulus program. Of the 104 EMR developers we track closely, almost 2/3rd specialize in less than 5 practice specialties. That isn't because they can't do more, it's because they specialize in certain medical specialties. Excluding them, excludes EMRs for mental health, and other smaller specialties, which are not well served by larger EMR developers that have focused on specialties with a greater number of physicians.

Regarding interoperability, current standards are adequate, what is not adequate is current compliance by some well-known vendors. Therefore **MU should mandate full compliance and demonstration of the same via the IHE/HIMSS/RSNA Connectathons**. This also provides a useful measurement. Each EMR must demonstrate full connectivity with 10 others in year one, 15 in year two, 20 other EMRs in year three, 30 other EMRs in year four, etc. It is like 'gas mileage' requirements, something that can be engineered starting NOW. All interfaces must support CURRENT connectivity standards, and be kept current with future enhancements to those standards.

eRx, CPOE and ePharmacy – sure, definitely. Surescripts/RXHub is fine. Don't compete with the private sector, use it to achieve your goals. Each should be a meaningful use criteria. LOINC codes for national labs should be written into the CLIA certifications for nation labs, and it would get done tomorrow. Go at it from that angle. SnoMed for data structuring is troublesome, because it is not a front end vocabulary, nor implemented so that its domain space is limited to current conditions and problem lists. It slows down MD charting which is why is has not taken off. Why not include Medcin from Medicomp. Works faster, provides cross-walk to SnoMed on the back end. It has enough clinical detail to solve all but research needs. Don't make the EMR into a research tool and then burden every MD in the country by mandating it. You can tell doctors to a point, but don't dismiss what happened in the UK when the government told them what they would adopt. $18 billion and 7 years later, it still hasn't been adopted and the problem is publicly criticized and made light of. It's NOT just about the money, it's also about the burden of the slower workflow. Don't use data from government hospitals to draw conclusions about non-government, community hospitals. The providers are different. The funding is different. The patients are different and so will be the outcomes.

Regarding quality and outcome measure. Yes, we must include them in 'meaningful use', but the trouble is they are fragmented and spread across too many special interests. Establish the disease states for "mu" for the first 2 years, then more for the next 2 years, etc. and get rid of the duplicates and variations. This will clarify what is THE QA Standard and what the vendors have to build to. Having too many variations of too many standards simply fragments the markets and undermines what otherwise might be achieved.

Thank you for your consideration. We look forward to making our data available to you on some basis to help you conduct your modeling of 'meaningful use' alternatives and the impact any set would have on all the significant EMR developers that participate in both our EHR Selector and in our annual MSP/Andrew EMR benchmark.

Sincerely,

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