



COLLEGE OF HEALTHCARE
INFORMATION MANAGEMENT EXECUTIVES

Meaningful Use Criteria Spark a Range of Responses

Big challenges await organizations hoping to qualify for ARRA stimulus funds

By Fred Bazzoli, Senior Director of Communications

Health care organizations are voicing concerns over the specifics of the meaningful use provisions for IT adoption, worried that the targets are too ambitious and too rigidly laid out to achieve the goal of accelerating IT adoption.

While generally lauding the scope, breadth and vision of the plan, HIT leaders expressed concerns that details of the plan underestimate the extent to which people and processes will need to change to effectively incorporate information technology in care delivery.

Other organizations, including CHIME, also are questioning if aggressive goals included in the matrix will effectively encourage a wide range of organizations to briskly move forward with IT adoption. If the magnitude of the goals appears too great, the elements in the matrix could have the effect of discouraging providers that can't mount a full-scale effort to implement HIT.

The Definition's Importance

Defining meaningful use of health information technology has become a key concern in the industry because it's one of the key qualifiers that will determine whether healthcare organizations will receive increased reimbursement for implementing HIT, as outlined in the American Recovery and Reinvestment Act of 2009. ARRA stipulates that there must be "meaningful use" of electronic health records for providers to receive reimbursement starting in fiscal year 2011, which begins October 1, 2010.

On June 16, a workgroup of the 20-member Health IT Policy Committee released its report and a detailed meaningful use matrix, which lays out health outcomes

policy priorities, care goals, and then objectives and measures for 2011, 2013 and 2015.

“The journey to a transformed health system requires meaningful use of transformation-capable HIT,” the workgroup’s report said. “The proposed meaningful use criteria for 2011 and beyond provides escalating capabilities, balancing urgent need for reform and the feasibility of what is achievable.”

Many entities, ranging from individuals to professional and industry associations, were expected to provide written comments by June 26 to the Office of the National Coordinator for Health Information Technology. Those comments and other feedback from the HIT policy committee are expected to be incorporated into a refined version of the meaningful use matrix. The policy committee recommendations are expected to be considered by the Centers for Medicare & Medicaid Services when the agency crafts a final rule, which is expected by the end of the year.

In crafting its response, CHIME coordinated efforts with its collaborative partner, the American Hospital Association. The coordinated response was intended to emphasize key points of common concern to both organizations, while the CHIME response detailed issues that are particularly critical to CHIME members, said Richard Correll, CHIME’s president and CEO.

While the industry has expressed general support for the priorities and ultimate vision of using IT to improve care, there’s a counterbalancing concern for how quickly organizations can computerize, especially with the first set of objectives looming slightly more than a year from now.

Can CPOE be Fast-tracked?

Drawing most of the concern in the initial matrix from the workgroup is the objective of using computerized provider order entry (CPOE) “for all order types, including medication.” Many HIT executives say that the that few provider organizations have CPOE in place today; and because of the time needed to get such systems installed, accepted and regularly used by clinicians, facilities will have a hard time meeting that requirement.

“With only 8.6 percent of hospitals reporting that they have CPOE installed and operational – and assuming there is another percentage that have implementations in process – I’m uncertain as to how many will be able to accomplish this very complex and complicated implementation,” said Chuck Christian, CIO and director of information systems for Good Samaritan Hospital in Vincennes, Ind.

The desire for all healthcare organizations to have order entry systems in place is important in the eyes of those who developed the meaningful use matrix, said

Marc Probst, CIO of Salt Lake City-based Intermountain Healthcare and a member of the overall HIT Policy Committee that will advise ONC.

“I understand the intention and the way it supports the broader meaningful use vision,” Probst said. “However, I am concerned about about the ability for organizations to successfully implement CPOE in such a short time. If you haven’t made the decision right now to choose a product for CPOE, the chances of you getting this selected and implemented, with workflow changes made, are pretty slim.”

The matrix also doesn’t address the percentage of clinician orders that must be made through computerized systems, as a part of the whole. Winning clinician adoption of computerized ordering is another aspect of implementation that takes time, Probst said.

Implementing CPOE requires organizations make a cultural shift in how they deliver health care, said Joanne Sunquist, CIO of Hennepin County Medical Center in Minneapolis, which has a CPOE system in place. “The process and people pieces are always harder than the technology piece,” said Sunquist, who also chairs CHIME’s board of directors.

While challenging, the CPOE goal laid out in the matrix “is a reasonable stretch goal,” said Robert Murphy, MD, chief medical informatics officer for Memorial Hermann Healthcare System, a Houston-based integrated delivery system. “But for small hospitals and physician offices, they don’t have the IT staff and clinical support to do this. These are not out-of-the-box systems. These require some forethought about what the deploying organizations are trying to accomplish.”

Flexibility in Sequencing

The matrix sets clinical documentation and medication administration using bar coding as objectives for 2013, and several IT executives suggested that some organizations might find it easier to implement those applications before CPOE.

“In order to provide the clinical decision support functions for CPOE and prevent errors from reaching the patient, the clinical documentation and other clinical integrations must be in place first,” Christian said.

Some organizations offered comments on the matrix suggesting that any meaningful use assessment should incorporate a flexible design that enables health care organizations to implement IT in a way that makes sense for them, without locking them into a rigid schedule, such as the current matrix does. CHIME’s response, for example, notes that “all participants in healthcare may have different reasons for their sequencing,” and it suggests defining a total number of required functions as a final goal for a meaningfully used EHR, and then “permitting flexibility in sequencing these functions for each milestone year. This...use of ‘building blocks’ which are cumulative over the history of the

program will reward hospitals for making progress toward (meaningful use) goals.”

“Having been in this business for 30 years, the idea of ‘one size fits all’ IT planning, the idea that organizations follow a very logical pathway to introduce IT into an environment, well, none of that is true,” said William Bria, MD, chief medical information officer for Shriners Hospital for Children and president of the Association of Medical Directors of Information Systems.

Costly implementations

Trying to put complex applications on a fast track toward implementation will involve additional expenses in advance of when organizations will begin to receive payments from Medicare to reward them for meaningful use of HIT.

Data from a recent survey already indicates that providers are uncertain whether the federal stimulus package will be effective in encouraging IT adoption. IVANS, a supplier of electronic data interchange and network services to the insurance industry, said an April survey that drew about 500 respondents found that half of them believe that federal stimulus dollars will have little or no impact encouraging adoption of HIT.

As early as late last year, a survey by the National Alliance of Health Information Technology found that CIOs were planning to scale back IT spending and the implementation of programs, in response to hospitals’ overall response to the faltering economy. Most experts say health care organizations will be hard-pressed to find capital to quickly invest in IT.

“Many hospitals may not have access to the immediate capital required to purchase and implement the technology required to meet the objectives, especially in today’s credit market,” said Christian of Good Samaritan Hospital.

Organizations that have had to curtail IT projects will have a difficult time getting ambitious projects rolling in order to meet the stipulations in the current meaningful use matrix, said Karen J. Moore, vice president and CIO of Southern Regional Health System in Riverdale, Ga.

“Many CIOs have stopped projects because we didn’t have the money,” Moore said. CFOs want and need projects that produced significant ROI without negatively impacting the financial statements in the event that the organization has to restructure or refinance their debt to fund future capital investments. To fund ARRA today, I would in essence be robbing Peter to pay Paul.

“My hospital has always served an economically challenged population and has put off a clinical information technology investment we want and need to simply survive today,” she added. “I don’t think we are alone in what can best be described as a ‘kick the can’ information technology investment strategy. We’ll

just keep moving the decision down the road until there is adequate money to pay for it.”

Federal incentives, while significant, “are not so huge to make people take the risk of betting the farm” on IT, Bria said. “It will provide a little bit more of a push to those who have been thinking about this.”

Low bar vs. high bar

The high-stakes investment in HIT will mean that hospitals that aggressively pursue a strategy to implement technology to qualify for ARRA funding will need assurances that they’ll qualify for the additional reimbursement. Stettheimer doesn’t feel that comfort when he looks at the structure of the current meaningful use matrix.

“It’s shockingly out of sequence,” said Stettheimer, a CHIME board member. “All this accomplishes is that it ensures that stimulus funds will not be spent in 2011. We need to encourage progress by encouraging improvement in processes. Timelines and milestones would be better if they were relative to where the provider is currently. It would be better to have an approach whereby you’d move everybody along rather than having most people throw their hands up and feel like they’ll never get the funds.”

Several executives said the final form of the meaningful use criteria circles back to ultimate purpose that it hopes to achieve, and whether the criteria are meant to get all providers to implement IT or whether they are intended to only reward providers that achieve a level of IT that enables them to meaningfully use information technology to improve clinical outcomes and reduce overall health care costs.

“While I understand that things need to be phased in, I don’t think we should set the bar too low” for receiving ARRA reimbursement, said Sunquist of Hennepin County.

“From our perspective, it’s gratifying that they are setting the bar pretty high and setting these aggressive expectations for meaningful use,” said Ferdinand Velasco, MD, chief medical information officer at Texas Health Resources. To qualify for ARRA stimulus funds in 2015, organizations are going to have advanced HIT systems that would place them at stage 6 or 7 of the seven-part scale developed by HIMSS Analytics to rank organizations’ IT capabilities. “For a lot of hospitals that have not even bought a system, they are looking at that and are probably stunned.”

Despite the concerns about the specifics of the matrix developed by the workgroup, many expressed admiration for the scope of the work that’s been done and the prospects that the eventual meaningful use criteria will help move HIT forward among health care organizations.

“Overall, I think the workgroup has done a tremendous job in a very short timeframe,” Probst said. “They have literally taken reams of input, organized it and provided a framework by which a solid recommendation can be made to ONC regarding meaningful use.”

“I really have confidence that (the workgroup) will hit a balancing act,” said Murphy of Memorial Hermann. “People are going to have to be patient with them, now that we have something to respond to. They can really look at this and begin to make some plans.”