



Position Paper

**Comments on “Meaningful Use”
Working Group Proposal**

As Presented to the Policy Committee,
June 16, 2009

Introduction

Picis, as a leading US healthcare information technology provider, has been focused for the past several months, along with other vendors, on providing opinion and guidance to the Office of the National Coordinator (ONC) in the development of the criteria around “meaningful use”. We were very pleased to see the progress made by the Meaningful Use Working Group in its report to the Policy Committee on June 16.

We would like to take this opportunity to provide feedback on the initial recommendations, and have organized that commentary in the following manner:

- Recommendations with which we agree wholeheartedly, in both the goals themselves and the means the Working Group presented for achieving them;
- Recommendations for which we agree with the goals, but urge different or alternate means be considered;
- Aspects of “meaningful use” we see as not addressed in the Working Group’s recommendations, or which we believe will require further illumination in the future; and,
- Areas in which we believe there are still questions to be answered.

In Full Agreement – Alignment with Both Goals and Means

We are pleased and heartened that much of the discussion is now being couched in terms of the broader context of healthcare reform, with a focus on improving the well-being of the patient-taxpayers. There are thus a number of areas in which we agree wholeheartedly with both the goals expressed by the Meaningful Use Working Group and the means it has proposed:

- The **predictability** of implementing ARRA HITECH in three well-defined phases of two years each. This will set common expectations for all involved, and provide a reliable roadmap for all parties. The progression outlined closely parallels the proven formula of **automation, optimization and transformation** works consistently among our hospital customers, and we believe it will do the same across the healthcare continuum.

- The emphasis on, and enumeration of, various high-level national healthcare **policy priorities**:
 - Improvements in quality, safety, efficiency and a reduction in disparities;
 - Patient and family engagement;
 - Better care coordination;
 - Improvements in population and public health; and,
 - Guarantees of privacy and security.

Among these goals, we find **maximizing care coordination** to be the overriding and most important. A recent study indicates that less than two percent of hospitals can claim a fully-automated EHR, and less than 10 percent even a partial EHR¹. Further, those institutions that can claim an electronic record often have many applications that are not contributing to a widely-available electronic record, resulting in information “silos”, making information unavailable to clinicians in other institutions, physicians’ practices, and to the patients themselves.

In Agreement with the Goals, Request Further Consideration as to Means

As with any such ambitious program, there are many means to achieving the laudable goals outlined. There are thus a few cases in which we would urge the Policy Committee consider alternative means to those put forth by the Working Group:

- **Settle for nothing less than an all-electronic record** – we believe that if we all focus on the outcome of any clinical episode, the record of that encounter, we will best serve the interests of the patient-taxpayers, and bring about the improvements in healthcare quality and cost-effectiveness envisioned. The entire US healthcare system is burdened by excessive paperwork and a general lack of automation, contributing to the highest per-capita healthcare spending in the industrialized world, low patient satisfaction, and frustration shared by all the participants. We advocate that everyone involved focus on the “R” in “EHR”, and agree on such parameters as data format and record content, interoperability, portability, security, and privacy, and then “let a thousand flowers bloom”, in terms of the software required to meet those needs. Paper should be unacceptable as a means of documentation, from the word “go”; otherwise the system will continue to struggle.

- **Be less punishing in privacy and security** – while absolute faith must be available that one’s personal health information is well-protected, one aspect of the Working Group’s matrix seems unduly harsh: the assertion that “an entity under investigation for a HIPAA privacy or security violation cannot achieve meaningful use until the entity is cleared by the investigating authority”. This would seem to violate the “innocent until proven guilty” principle of the American legal system, and would have a chilling effect on the adoption of healthcare IT, thus delaying the desired adoption effect. We recommend instead that any payments be revoked and returned if and when the entity is found guilty of a violation, as restitution for the (now proven) violation.
- **Phase in requirements for use of CPOE over time** – we believe there has been undue attention paid to the general goal of initiating computerized physician order entry (CPOE) across the broad hospital base as an early priority. As with any number of other areas involved in the recommendations, the ultimate goal of 100% adoption and use of CPOE for all types of orders is laudable, but probably not achievable in the short term. It is our experience that the lack of comprehensive, intuitive, cognitive systems in place today leads to a lack of physician buy-in and adoption.

Thus, with CPOE, we recommend adoption of a similar, three-phase implementation approach, matched to the other provisions for 2011, 2013, and 2015:

- Focus on ePrescription interfaces between clinical applications and pharmacy systems (internal to the hospital and with external exchanges) in the first phase (2011). This would include allergy and interaction checking to reduce medical errors;
- For 2013, add requirements for the capability to provide interfaces for all Labs, Radiology and other diagnostic and testing departments in the hospital, and introduce elements of Advanced Clinical Order Management (ACOM), including efficacy and cost optimization; and finally, for 2015,
- Mandate full deployment of ACOM principles to include interfaces and decision support capability to ensure efficacy and cost optimization.

Unaddressed Issues

We continue to believe that prioritization should be placed on the **highest impact areas** of the hospital first. One question from the hearing attendees zeroed in on the lack of specific “meaningful use” measures around specialties such as OB/GYN. We echo that concern.

Historically, inpatient EHR systems have offered only limited functionality in these high-acuity areas, and have not been able to garner widespread clinician adoption. Specialized systems for these areas offer the deep clinical information and interoperability required for effective care continuity central to “meaningful use”. They also offer advanced analytics, automated quality reporting and clinical decision support. Further, they often achieve clinician adoption rates in the 90+% range, ensuring fewer gaps in the electronic record.

We believe that the Certification and Adoption Working Group must provide a mechanism for hospitals to prioritize, procure and implement IT for these specialty areas in a modular fashion, so that they may receive full credit for “meaningful use”.

The Certification and Adoption Working Group is clearly early in its contribution to the definition of “meaningful use”. As it proceeds with its work, we recommend that the regulations and certification processes focus on the automation of the areas of highest cost intensity first. Not all hospital care areas are created equal, in terms of their contribution to the nation’s healthcare bill. In particular, surgery by far accounts for the largest proportion of hospital revenue, and thus payer cost (payers including the Federal and state governments, in addition to private insurers and patient self-pay).

Table 1 shows the breakdown of hospital revenue by specialty from a survey conducted in 2007 and 2008².

Specialty	Average Revenue Generated	Percent of Total
Surgery (all types)	\$6,933,333	21.4%
Cardiology	\$2,629,051	8.1%
Emergency Medicine	\$2,037,500	6.3%
Radiology	\$1,988,888	6.1%
Internal Medicine	\$1,933,334	6.0%
OB/GYN	\$1,744,444	5.4%
Oncology	\$1,685,714	5.2%
Family Practice	\$1,658,823	5.1%
Gastroenterology	\$1,462,500	4.5%
Pulmonary	\$1,462,500	4.5%
Urology	\$1,357,142	4.2%
Otolaryngology	\$1,333,334	4.1%
Occupational Health	\$1,250,000	3.9%
Nephrology	\$1,166,666	3.6%
Psychiatry	\$1,045,454	3.2%
Pediatric	\$981,818	3.0%
Ophthalmology	\$928,571	2.9%
Neurology	\$833,333	2.6%
Totals	\$32,432,405	100.0%

Table 1 – Breakdown of Hospital Revenue by Specialty, 2007/08

As can be seen, nearly 60% of revenues and costs are concentrated in the top six areas (surgery, cardiology, emergency, radiology, internal medicine and OB/GYN), and we advocate that certification programs for these areas of the hospital receive the highest priority, even if it requires a “crash program” for certifications before 2011.

Eighty percent of costs would be covered by the above six specialties plus the next set down the list (through Otolaryngology), and should be dealt with in the 2013 phase. The third and final wave (2015) would include the remaining departments/specialties, thus achieving house-wide automation, but doing it in a logical and cost-effective manner over a time period that hospitals would find achievable.

We therefore recommend that the Certification and Adoption Working Group place immediate priority and focus on the following care areas, where the impact on care quality and efficiency for the entire hospital will be most profound (please note that CCHIT certification programs already are in place for Inpatient EHR and Emergency Department systems):

1. Operating Room/Surgery
2. Critical Care/ICU (including surgical, cardiac, neonatal and internal medicine)
3. Cardiology
4. Radiology
5. OB/GYN
6. Oncology

Key Questions Remaining to be Answered

The Policy Committee has made an outstanding start on the “meaningful use” definition. As its work continues, and as it guides the work of the Standards Committee, we recommend that the following key questions, which were not addressed in the recent Policy Committee meeting, remain clearly in sight:

- **When and where will “meaningful use” be measured?** – even in a self-attestation system, there is likely to be an after-the-fact auditing provision. If a hospital has claimed “meaningful use”, and it is questioned, will it have to demonstrate achievement of the parameters in the matrix house-wide, or by department? Will it be measured by episode or by discharge? If it’s measured at discharge, and hypothetically that percentage of discharges is met solely through the ED or OR, would that one department suffice to show “meaningful use”?

- **Interoperability** – one of the keys to making healthcare reform and “meaningful use” actionable is establishing and maintaining interoperability between systems. At Picis we are committed to the standards of the IHE Technical Framework, and the related HITSP Interoperability Specifications which are emerging in this area. We hope that the Policy Committee and/or the Standards Committee will affirm this set of standards for such important items as clinical summary formats (CCD, for example) and file formats and transfer mechanisms (HL7 version 3, e.g.). This would also clear up questions as to the format of clinical documentation required in each phase (e.g., is a PDF output sufficient in the early phases, leading to a requirement for coded data later?).
- **Hospital department assignment (inpatient vs. outpatient)** – the parameters in the Meaningful Use Matrix break down along the lines of inpatient and/or outpatient applicability. Several hospital departments function as both, and we would like to see some clarification. For example, roughly 80% of Emergency Department patients are treated and discharged, but the remainder become inpatients. Similarly, most surgeries are conducted as inpatient stays, but an increasing proportion are ambulatory. In both these cases and others, some guidance as to which matrix parameters apply to which departments will surely be helpful to hospitals and vendors alike.

It may be that the Certification and Adoption and HIE Working Groups are prepared to make these contributions to the overall “meaningful use” definition, and if so, we look forward to their deliberations in these important areas. It would also be stating the obvious to note that the percentages called for in the Meaningful Use Matrix will need to be quantified, as “the devil is in the details”.

¹Jha et. al., “Use of Electronic Health Records in U.S. Hospitals”, New England Journal of Medicine, 16 April 2009.

²From a study by Jackson and Coker, and consistent directionally with other such examinations of hospital revenue by department.

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