Meaningful Use: Notes from the Journey

By Chris Dimick

After debate, speculation, and anxiety throughout the industry, the first physicians and hospitals have embarked on stage 1 of the meaningful use program. So far… so good.

The first physicians and hospitals have embarked on stage 1 of the meaningful use journey; it has been nine months since the program launched. And while it is a long voyage to the new world, the first reports are positive. The winds have been a little light, the seas have been rough in patches, but the boats are launched and no one appears to have sunk.

None of this was a certainty last summer when the final rule was published. The rule attempted to balance Congress's intent to drive dramatic improvements in care outcomes through health IT with the reality of the industry's readiness-both providers and vendors-to take on dramatic change.

At the time, there was little agreement over the balance it struck. Some in the industry said the requirements were too easy; others said they were too hard. Now both groups appear to be right. Although some challenges have been widely shared, the difficulty providers had in achieving the stage 1 requirements largely reflected how much prior experience with health IT they had.

Even the program's relatively slow start may not be surprising given how difficult it was to predict how many providers would join the program in its initial months.

However, what does seem certain at this point is that the program is working. Some providers are struggling more than others, but overall it appears that everything is going according to plan.

The Results-So Far

Congress set aside funds for an EHR incentive program in the American Recovery and Reinvestment Act of 2009. It left the details up to the Centers for Medicare and Medicaid Services (CMS), which issued a final rule detailing the first stage of the program in July 2010.

Through the program, developed with the Office of the National Coordinator for Health IT (ONC), eligible providers were offered incentive payments for meeting a set of criteria for the meaningful use of certified health IT systems. On the Medicare side of the program, physicians can earn up to $44,000, with hospitals eligible for millions based on specific criteria. A similar but separate program was created for Medicaid, administered through the states. CMS and ONC introduced the concept of stages in an attempt to ease providers into the program. With each stage, the objectives and their requirements will become more ambitious.

Registration for the program opened in January 2011. Attestation began in April 2011, and some providers were in line to receive the first incentive payments. Some, but not most.

Speaking at an August 3 meeting of ONC's Health IT Policy Committee, CMS representatives reported that 2,383 eligible professionals and approximately 100 hospitals had attested for the Medicare program though July.

All of the hospitals and all but 137 of the physicians attested successfully, said Robert Tagalicod, director of the Office of e-Health Standards and Services at CMS. In total, nearly $400 million in payments had been issued through both programs during the period.

The number of participants may seem low, but it does not indicate a lack of interest in the program. Approximately 77,000 providers have registered for the programs, and attestation is growing each month. The number of physicians who successfully attested to stage 1 jumped 147 percent from June to July, rising to 566.

"The numbers are appearing to be increasing, and so we're hopeful that that will be a continuing trend," Elizabeth Holland, CMS's director of health IT initiatives group, told the Health IT Policy Committee.

CMS respresentatives estimate there are "hundreds of thousands" of eligible professionals and hospitals, according to a discussion with the policy committee.

On the Medicaid side, where 21 states were open for registration as of August, incentives have been paid to 3,500 physicians and hospitals. Under the Medicaid version of the program, providers can receive payments in the first year for the adoption, implementation, and upgrade of certified EHR technology. They do not need to demonstrate meaningful use.

On average Medicare's early attesters who successfully met the measures did not just squeeze by. Instead they "greatly exceeded" the required measurement, Tagalicod told the policy committee. For example, providers on average used computerized physician order entry for 87 percent of medication orders for unique patients during the attestation period, far beyond the designated threshold of 30 percent.

However, CMS warns against reading too much into the early results. In the case of CPOE, for example, the percentage may fall in time because it is assumed that many of the early attesters have mature systems in place and their use is consequently higher than that of new users. Rates may decrease as new adopters begin to attest.

Payment Plans

In an attempt to encourage eligible professionals to join the Medicare program quickly, CMS and ONC established a payment schedule that offered the highest dollars to the earliest participants. Those who qualify for a first payment in 2011 and 2012 are eligible to receive the full $44,000; the total diminishes in the following years. The incentives stop and the penalties start in 2015.

	Qualifies to Receive First Medicare Incentive Payment in...				
Payment Amount by Year	**2011**	**2012**	**2013**	**2014**	**2015**
2011	$18,000	-	-	-	-
2012	$12,000	$18,000	-	-	-
2013	$8,000	$12,000	$15,000	-	-
2014	$4,000	$8,000	$12,000	$12,000	-
2015	$2,000	$4,000	$8,000	$8,000	-

2016	-	$2,000	$4,000	$4,000	-
Total payment	$44,000	$44,000	$39,000	$24,000	-

The Medicaid program differs significantly. Eligible professionals receive the same payments over a six-year period, regardless of when they start: $21,250 in the first year and $8,500 in each of five subsequent years. They must qualify for their first payment no later than 2016. There are no penalties under the Medicaid program.

Hospitals in the Medicare program can begin receiving EHR incentive payments in any year from FY 2011 to FY 2015, but payments will decrease for those that start receiving payments in 2014 and later. Hospitals that do not successfully demonstrate meaningful use by FY 2015 will be subject to payment adjustments.

Eligible hospitals that qualify for Medicaid incentive payments may begin receiving payments in any fiscal year from 2011 to 2016. While the law defines a payment year in terms of a federal fiscal year (FY) beginning with FY 2011, a hospital does not have to begin receiving incentive payments in FY 2011.

Smoother Sailing for Experienced Crews

The biggest achievement of stage 1 to date has been just getting people onboard a program that will equip a nation of providers to better treat their patients, says Sanin Rahman, senior consultant at consulting firm Arcadia Solutions.

"One of the biggest successes is the fact that the industry took to meaningful use as much as it did, and the fact that it is driving more and more providers at a scale-that is honestly unprecedented-towards EHRs," Rahman says.

CMS intended stage 1 primarily to motivate providers to implement EHRs, more so than driving improvements in healthcare quality. That comes later, says Rahman, who is currently consulting with healthcare organizations on how to participate in the meaningful use program. While many providers use some electronic processes for practice management, a large section still needs to implement a robust EHR, the type certified for use in the federal program.

Thus, the providers best positioned to receive incentive payments early are those whose EHR implementations were under way when the incentive program began. Larger hospitals with greater resources, planning infrastructure, and governance in place also have an advantage over smaller hospitals and practices. Further, hospital systems running a single, enterprise EHR platform have an advantage over physician practices that may need to upgrade a variety of interfaced systems and retrain staff before they can attempt the stage 1 measures.

In general, the incentives paid to major EHR users won't cover the cost of installing the equipment. NorthShore University HealthSystem, based in Evanston, IL, was an early adopter of health IT, implementing its first EHR in 2003. NorthShore reported its stage 1 measures on the day attestation opened in April, and soon after it received its first incentive payment of $8 million. More money will come in later stages. However, it will not be enough to cover NorthShore's overall IT investment.

"We spent well over $100 million [on the EHR] overall, putting it in, supporting it, and going forward with staff, software, and hardware," says Tom Smith, chief information officer at NorthShore. "So it is important to understand these are nice dollars to get, but they don't really pay for the product."

The gap between incentive payments and total cost of ownership may be less for smaller physician offices that have lower overhead than a hospital. In those cases, the incentive payment may come closer to offsetting the cost of a smaller EHR system.

But the incentive payments were not NorthShore's main motivation to enter the meaningful use program. As in many organizations, care improvement has been the driving force in implementing EHRs.

"In this case we certainly didn't look at this as just an IT activity," Smith says. "There were many, many operational people involved from hospital presidents to the people who run the nursing floors to the people in medical records."

Once an organization successfully attests, CMS has 45 days to send payment. Payments have been promptly received. Wellmont CVA Health Institute, a 33-practice cardiology organization, received its incentive payment 35 days after attesting in April, according to Jack Sunderman, director of IT at Wellmont.

Wellmont staff members started preparing for stage 1 in November 2010, carefully reading the program criteria to see how their use of their current EHR stacked up to the measures. They found they were "80 percent of the way" to meeting the stage 1 objectives, Sunderman says.

"The reason we didn't find any of these [measures] extremely hard is because we were already positioned so well," Sunderman says. "If we had tried to do this three years ago, I would have found all of these extremely hard because we would have been changing processes and trying to implement a computer system and making sure we are capturing all the right data at the same time."

Ship's Log

Although stage 1 of the meaningful use program launched this past January, preparation for the voyage had been under way for years. Planning for future stages of the program will continue for several years more.

FEBRUARY 2009
Program mandated within American Recovery and Reinvestment Act

JANUARY 2010
Proposed rule: meaningful use stage 1

Proposed rule: EHR standards and certification criteria

JUNE 2010
Final rule: temporary certification program

JULY 2010
Final rule: meaningful use stage 1

Final rule: EHR standards and certification criteria

FALL 2010
First EHR products certified for incentive programs

JANUARY 2011
Medicare program registration opens

Medicaid programs open in 11 states; first Medicaid payments issued

Final rule: permanent certification program

APRIL 2011
First providers attest under Medicare program

MAY 2011
First Medicare payments issued

AUGUST 2011
Medicaid programs available in 21 states

On the horizon…

November 30 2011
Last day for eligible hospitals and critical access hospitals to register and attest to receive an incentive payment for federal fiscal year 2011

Late Fall
Proposed rule expected: meaningful use stage 2

January 2012
Permanent certification program scheduled to open

February 29 2012
Last day for EPs to register and attest to receive an incentive payment for calendar year 2011

Summer 2012
Final rule expected: stage 2

Stage 2 EHR standards and certification criteria required

January 2013
Stage 2 program scheduled to begin; delay possible

Technical, Operational Challenges

Meeting the stage 1 measures has not been without challenges, even for professionals and hospitals that successfully attested.

The first challenge came in digesting the final rule itself. Several hundred pages long, providers had trouble summarizing measure requirements in a way that translated into process and system modifications, says Erica Drazen, managing partner at consulting firm CSC's Global Institute for Emerging Healthcare Practices. The list of frequently asked questions on the CMS Web site had grown to 120 by this summer.

Rahman answers his share of frequently asked questions, also. His clients commonly ask, "Exactly what do I need to tell my physicians to do?" he says.

Vendors, too, have been working to understand the details and adapt their systems to the program's requirements.

Even EHR products certified for use in stage 1 may not have all the kinks worked out, Rahman says. For example, one of his clients struggled in meeting the requirement to electronically exchange health information with other entities. In speaking with the system vendor, Rahman says, "it turned out there was some health information exchange-related infrastructure issues, and [the EHR] wasn't reading the data properly." The problem took the vendor and provider weeks to solve.

Reporting has been another early problem. NorthShore has employed reporting tools outside the EHR for its own data gathering; however, in the meaningful use program, attesters must report directly from their EHRs.

That is a challenge, Smith notes, because the systems "are not really reporting tools to begin with." Quality reporting requirements are difficult to meet because many certified EHR systems cannot adequately capture the quality data needed.

The certification criteria only called for EHRs to calculate and report quality measures, not capture the information, Drazen says. To fix this issue, CMS clarified that providers only have to calculate and report on data that are in their EHR. It is a short-term fix that decreases an EHR's usability for quality measures.

CPOE Issues

The stage 1 requirements related to CPOE call for providers to use CPOE for medication orders with more than 30 percent of patients. Meeting the measure has been tough for providers who started from scratch, Drazen says.

"Putting [CPOE] in is not the challenge, but putting it in in a way that optimizes the probability that people are going to use it is challenging," she says.

At Wellmont, CPOE was already in place, but meeting the stage 1 measure was still tricky. First, physicians had to be reminded to use the functionality rather than fax prescription orders.

"I had to teach the providers that faxing was not e-prescribing-faxing is paper," Sunderman says. "From their point of view it was the same thing. It was getting them to click a different button."

More CPOE challenges are ahead for providers who are focused solely on meeting the stage 1 criteria. Some providers are working on near-term solutions, setting up systems that manage medication orders. However, as the meaningful use stages advance, the program will add more complex CPOE measures, requiring these providers to again modify their systems.

In addition to enabling medication orders, providers should be enabling CPOE to manage lab and imaging orders, Drazen advises. "You don't want three different processes for how the doc has to order stuff. Indeed, stage 2 [draft criteria do] require labs and radiology/imaging orders."

Providers should not focus on meeting specific measures, Drazen says, but instead implement systems that help them achieve long-term goals. Rather than ask, "How can I get 30 percent of my CPOE orders to meet stage 1?" she says they should say, "We are going to move to computerized ordering because it is safer and better."

Though CMS did not require detailed data reporting in the first year of stage 1-summaries are accepted instead-it will require more data in the future. Providers should practice recording this detailed data now so they can provide it in upcoming phases of the program, Smith says.

Reproducing Records Proves Difficult

Two of the hardest requirements for both hospitals and physicians are centered on providing patients with copies of their medical information. One difficult measure to meet is providing electronic copies of the information to 50 percent of patients who request it.

That's not a request many EHRs can easily accommodate, Rahman says. There isn't a big green button on an EHR that will collect the patient's information, burn it to a CD, eject the CD, and have the CD ready for pick up, he says.

NorthShore offers patients an electronic portal they can use to access their records almost as soon as the data enters the EHR. But NorthShore had difficulty tracking who requested information, data needed for calculating performance against the stage 1 criteria, Smith says. In order to ensure it met the meaningful use measure, NorthShore decided not to include the portal in its meaningful use reporting, instead tracking only those patients who requested an electronic copy of their records outside of the portal.

The offline requests were rare-only a couple each week-but NorthShore still was challenged to fulfill half of the requests within the required three-day deadline. The process became fairly manual as well, requiring a written request to the medical records department, preparing the information, and then producing and sometimes mailing the electronic copy of the records to the patient.

"That one [measure] gave us the most trouble," Smith says. "Getting that done in three days was a challenge for us."

Physicians have struggled meeting a similar requirement to deliver clinical summaries to patients within three days of their visits. The electronic and personnel processes for this task have not been developed in most practices, meaning both vendors and physicians needed to establish a system to get patients the information, Rahman says.

"There are a lot of practices that haven't done this in the past," he notes.

This, of course, was HHS's motivation in writing the requirement, one of the program's attempts to get providers started toward more patient-centered care.

Providers are finding the simplest way to meet the measure is to hand patients their clinical summaries before they leave the office. But doing this requires providers document their encounters and pull other information into the summaries before the patient leaves.

Wellmont struggled with this stage 1 measure before working with its vendor to develop a series of drop-down menus that providers could select during or just after the patient visit. The selections would summarize the encounter.

"Being a specialty practice a lot of the summaries are very similar," Sunderman says. "You are overweight, you are proper weight, you are or aren't changing drugs. So those statements we were able to put into very quick lists that the doctor could simply click the key statements he needs for the summary."

This information was added to other standard clinical summary information such as prescriptions or test orders and then handed to the patient at checkout.

Program Achieves Balance

Rahman believes that stage 1 strikes the intended balance between difficult but not discouraging-he has heard from clients that the measures were too easy and too hard.

"I think it does as good a job as possible, and it is a very complex environment in trying to get a lot of people on a level playing field," he says.

The carrot and stick approach in the Medicare program seems to be working for larger hospital systems. Realizing they must become meaningful users by 2015 or face payment reductions, they have joined early to take advantage of the incentives.

While the incentives for hospitals do have a limit, the penalties that come after 2015 are uncapped.

"Because the penalties are uncapped and based on admissions, the bigger hospitals have bigger potential penalties," Rahman says. They quickly realized, "'I could gain $8 million, [or] I could lose $16 million.'"

NorthShore started tracking the stage 1 measures in the summer of 2010 to ensure it could meet the measures in January, the start of the 90-day attestation period for those attesting in April.

While the health system was already meeting several of the thresholds, tracking its work on things like medication reconciliation and problem lists did lead to improved processes that will ultimately improve care, Smith says.

The problem lists went from general statements to more specific information, and medication reconciliation was done more robustly. While not very difficult, the program did improve care processes at NorthShore and many other early attesters.

This is the intent behind the meaningful use of health IT. But the bigger improvements to care are to come in later stages, once providers have passed their voyage's first milestone with stage 1.

Care Impact Comes Later

Many providers have been reacting favorably to the program, even if they are delaying their entry.

"This program was supposed to accelerate the adoption, and it certainly is doing that," Drazen says. "I haven't heard many people say that this requirement isn't important, or that this isn't going to have an impact."

Stage 1 is about getting the systems implemented and providers using them effectively, Drazen says. Stage 2 will have providers begin to use the information to find gaps in care, and improvements to care processes will come in later stages.

"It wouldn't be an expectation that you would see a big difference right now," Drazen says. "CPOE has the potential to improve medication management and avoid errors in medication, but the stage 1 requirement that requires clinical decision

support is really only on allergies and interactions. And that is not where the problems are occurring in hospitals now with medical errors. Only in the future stages... will we see the benefits."

Wellmont, NorthShore, and several other hospital officials agreed that the meaningful use program is a great thing for the industry.

"I think it is important to understand from our perspective that even the [measures] we had difficulty with, nobody questions the overall legitimacy of them," NorthShore's Smith says. "There was nothing we were asked to do…that we thought was a waste of our time or a bad thing to do. The same is true for stage 2.

"The whole idea of meaningful use I think is a very appropriate task."

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