Senate Finance Committee Hearing: "*Health Information Technology: Using it to Improve Care*"

On Wednesday, July 24th, the Senate Finance Committee conducted a hearing on leveraging health information technology (IT) for improving care. Witnesses for the meeting included:

- Dr. John Glaser, Ph.D., Chief Executive Officer, Health Services, Siemens Healthcare, Malvern, PA ***(eHI member)***
- Mr. Marty Fattig, Administrator and Chief Executive Officer, Nemaha County Hospital, Auburn, NE
- Dr. Colin Banas, MD, Chief Medical Information Officer and Associate Professor, Virginia Commonwealth University, Richmond, VA
- Ms. Janet Marchibroda, Director, Health Innovation Initiative, Bipartisan Policy Center, Washington, DC

The hearing began with introductory remarks by Chairman Max Baucus (D-MT), available here.

Ms. Janet Marchibroda began her testimony by highlighting the fact that electronic health records (EHRs) are succeeding, but there are still gaps with long-term care, critical access hospitals, and behavioral health as they do not qualify for the EHR Incentive Program (meaningful use). There is the need to prioritize interoperability of EHRs, allocation of resources and the focus of agencies to work together.

Marchibroda strongly recommended not delaying Stage 2 of meaningful use, to align expectations, and for the Centers for Medicare and Medicaid Services (CMS) to lead by example and share healthcare data to meet population health needs. Future stages should prioritize health information exchange and outcomes.

Dr. Glaser indicated Stage 2 has rather stringent requirements. The delay of publishing testing tools and clinical quality measure (CQM) specifications as well as confusing requirements have made meeting the timeline extremely challenging. There are also other regulatory programs competing for time and resources, such as ICD-10-CM/PCS and payment reform, which is creating a "perfect storm" situation and overburdening hospitals and providers.

In order to meet the deadline for the meaningful use stages and receive incentive payments, hospitals and providers are implementing EHRs too quickly and are not taking the time – nor are they afforded the time – to ensure EHRs are implemented well. Addressing workflow changes, training, and other necessary steps needed for successful and safe implementation has not been accomplished within the time allocated for Stage 1. Dr. Glaser's recommendations are:

1. **Extend Stage 2:** Allow time to effectively implement EHRs and extend Stage 2 until October 2015 (rather than October 2014).
2. **Flexible:** Modify the program to be less prescriptive and allow more flexibility. Keep the focus on interoperability and allow hospitals and providers to determine the best way to achieve the objectives and measures.
3. **New Care Models:** Stage 3 should support the transition to new care models and have less emphasis on features and functions.
4. **Rural providers and Critical Access Hospitals:** Allow for loans and/or grants to help them with EHR implementation.
5. **Interoperability:** Focus more vigorously on interoperability and aggressively push for the use of standards.

Mr. Marty Fattig indicated that rural and small providers continue to struggle with Stage 1 and cannot get timely attention from vendors to provide support to meet the criteria. With the aggressive timeframes for the Stages, Fattig expressed concern about patient safety issues as a result of rushing to implement and meet the requirements. As Dr. Glaser described, more regulatory requirements, such as ICD-10-CM/PCS and Accountable Care, are rapidly approaching and it is difficult to maintain a safe environment for patients.

Chairman Baucus questioned the panelists on whether requesting a delay in Stage 2 is simply an excuse, and if provided more time, would the ability to meet the requirements improve? The panelists responded that it is necessary to slow down the program, and research has shown that safely and appropriately implementing EHRs takes time.

Senator Michael Enzi (R-WY) asked the panelists for information regarding small and rural providers' inability to keep pace with other hospitals and providers. The response was very straightforward – there is a lack of resources, both financial and human, and there is just not enough to support the needs for achieving meaningful use. Health IT vendors are also experiencing a lack of capacity to support smaller and rural hospitals.

Sen. Enzi questioned the panelists on the ability of the agencies to anticipate the challenges met and what can be done to ensure a smoother rollout of the program. Dr. Glaser responded that the Office of the National Coordinator (ONC) Health IT Policy and Standards Committees, charged with making recommendations, were not aware of the magnitude of adoption challenges and had to make recommendations based upon their best knowledge.

Senator John Thune (R-SD) questioned the panelists on whether there was a way to design an extension that would enable additional time to meet the requirements for some providers while allowing more advanced providers to progress towards Stage 3 of the program. The panelists responded with recommendations to allow for some flexibility in meeting the timeframes and extending Stage 1 as CAHs are struggling to keep up. Before the industry moves on to Stage 2, we need to ensure Stage 1 is implemented well. There could be a possibility for grant or loan programs to assist with resources and support that initial investment to move forward.

Sen. Thune questioned whether there was sufficient pressure to have exchange of information in Stage 2 and what can the administration do to push for this with vendors. Replies from the panelists indicated there must be a change in the payment mechanism as well as a focus on further standards development to support information exchange.

To further the discussion regarding the need for a sufficient business case for interoperability, Marchibroda indicated that the increase of Accountable Care Organizations (ACO) and the need for improved clinical collaboration serve as a business case and incentive to make progress with interoperability efforts. She suggested aligning interoperability conversations of the meaningful use program with ACOs would be helpful in motivating the exchange of data.

Senator Thomas Carper (D-DE) questioned the panelists about the existing quality measurement programs regarding their adequacy and ability to meet the requirements. The panelists agreed there are challenges in the ability to capture data via the EHR and report quality measures. With the introduction of EHRs and the change in reporting quality measures via electronic methods, many components of a provider's workflow changes and creates "alarm fatigue" as they capture data just to collect the data. Many of the measures do not align with providers' specialty of type of care delivered and the requirement to meet the many measure reporting is very aggressive. The movement toward electronic clinical quality measures (CQMs) creates new challenges to ensure data integrity is maintained while capturing and storing the information. There are also costs associated with collecting and reporting the data, and improvement is needed to make the measures meaningful.

For more information, access to the witness testimonies and to view a recording of the hearing, click here.