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SETMA and Meaningful Use: Outline of SETMA's Deployment Part II
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SETMA's MU2 Dilemma

SETMA's MU2 dilemma stems from the fact that when we began using the EHR in 1999, our vendor did not have a data base which could be used. It further results from SETMA's adopting the ideal of EPM in May, 1999, which set us on a rapid course of healthcare transformation in which we outpaced other organizations and certainly outpaced our vendor in healthcare transformation. Now, we find ourselves in the position of using the EHR meaningfully as a transformative tool, but not being able to fulfill the requirements of healthcare reforms, which require uniformity in functionality. We either have to suspend transformation of our healthcare delivery in order to conform to the rules and regulations demanded by healthcare reform, or suffer penalties now and in the future, which penalties are likely to become more onerous in the next ten years.

After reading the MU Use Workshop Stage 3 Update (Paul Tang, Chair, Health IT Policy Committee), and seeing that almost all of the proposed elements are issues with which we have dealt with in our PC-MH, I was encouraged that if we can resolve the problems with MU2, SETMA can continue on our 19-year journey to healthcare transformation. SETMA is not only fulfilling the structural necessities of PC-MH; we have also achieved the functional and dynamic elements of PC-MH. The ONC's MU3 is probably going to require additional interoperability functions which will be a barrier to SETMA receiving recognition for the PC-MH work we are already doing.

In this context, I offer the following observations on SETMA and MU2. On November 26, 2013, it was confirmed to SETMA that even though our EHR vendor is one of only twenty-one vendors which have met certification for MU2, because our use of that vendor's platform is customized, we cannot use that certification to attest to SETMA's meeting of MU2 standards. Published reviews have suggested that the practices which are going to be "hurt" the most by MU2 are the early adapters like SETMA. Remember, in March 1998, when we bought our vendor's product, they had no knowledge base, so out of necessity we had to build our own. This is the foundation of SETMA's request for an exemption for four years. That exemption will

give us time to continue our transformation and to make the changes to our EHR which will allow us to meet MU2 and 3.

In 1999, SETMA's vision of EHR changed from simply being a tool for documenting a patient encounter, to being a tool for leveraging the power of electronics to improve care for individuals and to improve care of panels or populations. Through all of this, SETMA rapidly and continually improved and expanded our tools for transforming care. All of those tools can be reviewed at Electronic Patient Management Tools (EPM stands for "electronic patient management"). These tools are made available to everyone and anyone without cost and even though these tools have great value, they are not copyrighted. Their purpose is to improve healthcare for anyone who wishes to use them.

SETMA's major obstacle posed by MU2 is interoperability. SETMA is not unaware of the value of shared data. We utilize our EHR everywhere we see patients:

- In the hospital (4 different hospitals using the same EHR database)
- In the emergency department (three different ED using the same EHR database)
- In the clinic (six different clinics using the same EHR database)
- In the nursing home (32 nursing homes using the same EHR database)

Every patient encounter, every patient activation and engagement document, every patient plan of care and treatment plan, on every patient we treat is completed in the same EHR and is simultaneous available at every point of care. Within the next six months, a practice seventy miles away will joint SETMA and other clinics, hospitals, emergency department and nursing homes will be added, with the same connectivity and shared data.

Our sub-regional Health Information Exchange expands the reach of our patient-care information to many other providers and institutions. Our Patient Web Portal makes our patients' health information available to them. HIE is the foundation for allowing interoperability between healthcare providers and systems to exchange information about patient care. Even in their most basic form, HIEs allow for the transmission of useful data such as images and scanned reports. Even though these types of non-standardized materials may require the eye of a human for interpretation, they still provide highly useful information that can be used to improve patient care.

However, the further extension of an HIE is to use it to transmit information in a structured, standardized and codified format. Then, not only is the viewable information of the transmission useful to a healthcare provider, but it is then also coded in a format that a computer can understand and process. This then allows the power of electronics to also become part of the patient's care. That said structured, standardized and codified documents are great enhancement to interoperability but not necessarily a requirement.

SETMA totally agrees with the goals of interoperability. However, in order not to disrupt our progress, we need a temporary exemption from MU2. The criteria for granting this exemption for SETMA and for others are discussed below. We believe that if an organization meets the

criteria discussed, a four-year exemption would eliminate the disruption cause by the current deadlines and would allow the financial impact to be absorbed over a longer period of time.

Because a well designed and deployed HIE provides most of the functions of interoperability, we think our use of HIE diminishes the encumbrance our request for an exemption to MU2 has upon CMS's and ONC's goals. We also think that some of the exuberance for inoperability is misguided. That judgment is guided by our experience. In 1998, SETMA was prepared electronically to import a great deal of information into our newly launched EHR.

Before beginning the use of EHR to document patient encounters on Tuesday, January 26, 1999, SETMA used dictation and transcription for charting patient encounters. Therefore, in January, 1999, we had three years and six months of transcribed records. We employed a company to build an interface between Microsoft Word and our EHR vendor, so that we could place the word documents into the EHR. We thought it would give more credibility to our new tool to have 42 months of notes in the record.

The day we were prepared to "dump" the Word documents into the EHR, we stopped and asked ourselves, "When is the last time, we looked at a patient encounter note from six months or two years before in order to treat a patient?" We certainly looked at procedure results, at laboratory results and other historical data, but never at chief complaints, history of present illness, a review of systems, or a physical examination. Therefore, we made the decision, which turned out to be wise, to keep the word document file and the paper chart record according to statutory requirements, and to start the EHR record from the beginning. We extracted important diagnostic materials, allergies, medications, family, social and personal history, etc, but we did not extract the details associated with a single encounter.