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SETMA's Meaningful Use Two Dilemma Part II
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While 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:

1. In the hospital (4 different hospitals using the same EHR database)
2. In the emergency department (three different ED using the same EHR database)
3. In the clinic (six different clinics using the same EHR database)
4. 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.

My purpose in writing is to offer a reasonable and appropriate solution to our dilemma and that of many other meaningful users of the EHR. That solution is:

1. For CMS and ONC to recognize that the interoperability which MU2 requires is not based on excellent care but on an artificial standard. The elements of a patient encounter which have value to another provider are diagnoses, allergies, medications, past medical and surgical history, habits, demographics, and some laboratory values. This is not an exhaustive list.
2. Interoperability and Health Information Exchanges have different but complementary functions. Other elements of the record than those mentioned in 1 above, i.e., chief complaint, review of systems, history of present illness and physical examination are more appropriately communicated as a document through a Health Information Exchange.

   Placing these elements in structured fields presents a potential conflict as the receiving provider may find those elements in error and would have a difficult task distinguishing between the evaluation by the former provider and their own evaluation. Time would be required to document why contradictory history and physical data is in the same record. This also potentially creates a medico-legal problem if the data from another source is not clearly documented and then is not specifically contradicted by the receiving provider.

In addition to asking HHS, CMS, HIT and ONC to rethink these issues, we have the following concerns:

1. In a recent interview, Ms. Jodi Daniel, commented that ONC is determined to succeed with Meaningful Use. Here we have to define "success." I have no financial interest in any EHR. My concern about the unintended consequences of MU2 in reducing the number of EHRs from 500+ to 21, or so, is that it unfairly punishes the healthcare providers who unwittingly purchased an EHR which is inadequate. Success, rather than driving them out of business, would seem to require giving them time to make the changes necessary to meant MU2 standards, and if they attest to the fact that they are taking the necessary steps to meet the valid interoperability steps, for CMS to delay penalties for two year, i.e., to January, 2016.

   This does not compromise ONC's mission but it does make "success" bi-directional, i.e., not only the fulfillment of ONC's goals, but giving providers time to change. It would be difficult for me to ascribe "success" to a program which is going to punish physicians for having bought an EHR. Success would seem to dictate ONC facilitating providers who are willing to change. It is also reasonable to give vendors who are committed to meeting MU2 standards time to make the necessary changes. It is hard for me to imagine that

CMS and ONC would judge themselves to be successful if that success resulted in the dissemination of an industry which was created by the attempt to meet CMS' and ONC's goals established four years ago.

In SETMA, we work hard to improve our performance. We close our offices for a half day each month to teach our providers, to review performance, to find leverage points for improving that performance and for making sure that we are moving forward. This link is to a summary of SETMA's October, 2013 provider training: SETMA's Provider Training for October, 2013. Many other monthly meetings summaries are posted on our website at Presentations.

SETMA's goal is to be successful in achieving healthcare transformation and improvement, but we would never consider it a mark of success, if we established a standard of success which drove 2/3rds of our providers out of SETMA, but neither would we consider it a success if we forever endured substandard performance. Success would be a positive improvement in a reasonable time frame. In whatever time frame, we would consider ourselves a failure if healthcare providers were forced to leave healthcare due to our demands.

2. Here is our proposal and the content of our appeal for a temporary, four-year, exemption from MU2, interoperability requirements. For practices like SETMA who:

    a. Were early adapters (those who adopted EHR before 2006).
    b. Have demonstrated efforts and results of the use of EHR meaningfully with clinical decision support, addressing of ethnic disparities, use of analytics and the auditing of quality.
    c. Are participating in a Health Information Exchange.
    d. Have deployed a Patient Web Portal.
    e. Achieve Patient-Centered Medical Home of a high level from at least one agency (NCQA, AAAHC, URAC, and Joint Commission).

    that they be given four years to make the changes necessary to do interoperability which is clinically meaningful and that ONC work with these practices to define what meaningful, clinical interoperability is with a logical and valid distinction between the value of an HIE and interoperability.

Conclusion

It never occurred to SETMA that we would not easily qualify for MU2. Since discovering that we will not, we have found it will cost $500,000 to $1,000,000 to make this transition and it will require us to suspend our continuous quality improvement activities for six to twenty-four months in order to focus totally upon interoperability. Perhaps nothing is more illustrative of this transformation than SETMA's ***The Automated Team*** which is the logical conclusion to the promise of clinical decision support and which will have to be suspended in favor of ONC's reform requirements. The following is a link to the full explanation of ***The Automated Team***.

Hopefully it is obvious that SETMA is moving ahead with quality improvement and practice transformation and that our request for and exemption and for more time is not out of resistance to the future, nor due to slothfulness. It is our hope that though CMS and ONC have resisted the importations of others, that you will consider this request and proposal as reasonable and rational.