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INSIDE EDGE

HITECH, Stimulus, Meaningful Use: Finding a Framework for Decision-making

EXECUTIVE SUMMARY

At the time of this writing, David Blumenthal, MD, National Coordinator for Health IT, predicted that the final definition of meaningful use is unlikely to be ready until mid-to-late spring 2010. The definition, which will help determine if healthcare provider organizations qualify for incentive payments from Medicare and Medicaid under the federal stimulus plan, will be released in a preliminary version at the end of 2009 followed by a 60-day comment period.

Given the continuing ambiguity about meaningful use, what should health provider organizations do? More specifically, how should they even go about deciding what to do? In this issue of Inside Edge we rounded up a few of the "usual suspects" in our panoply of healthcare IT experts to ask those questions. Consultants are typically good at providing frameworks for approaching complex issues, so we interviewed two of the best—Deloitte and CSC—who also happen to be SI sponsors. Also, we talked to the CIO at Trinity Health, with dozens of hospitals sprinkled across the country, and the CMO at Memorial Hermann, with not quite a dozen facilities in the Houston metro area, both stellar SI member organizations.

In Deloitte's estimation

Consultants at Deloitte LLP are closely following HITECH, meaningful use and healthcare reform, and the Deloitte Center for Health Solutions provides updates on these issues at www.deloitte.com.

Despite the continuing ambiguity about the evolving guidelines, there's enough definition that health delivery organizations should not delay the journey, says Eric W. Finocchiaro, senior manager at Deloitte Consulting LLP. "A first step is to perform a HITECH impact analysis. Second, an organization needs to determine a quantitative estimate of how much money does this mean for my organization?" he says, adding that large physician practices and hospitals are the most likely beneficiaries of the stimulus because the incentives are additive whereas some of the costs can be leveraged.

Deloitte has developed an estimator tool to calculate potential incentive payments and penalties that it has run for about 30 health systems representing hundreds of hospitals. One lesson learned from experience with the tool, Finocchiaro says, is

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Deloitte.

Eric W. Finocchiaro, senior manager, Deloitte Consulting, Boston

"We believe there's enough directional information to drive effort, particularly on the quality, safety and efficiency side—and some on the HIE side."

Accelerate or evaluate

Robert Williams, MD, a director at Deloitte, says that anecdotal evidence bears out the fact that health organizations respond based on where they are in their CIS life cycles. "They've taken this as an opportunity to accelerate or stop and evaluate," he says. For example, an organization implementing CPOE might do a gap analysis specifically around functionality that it expects to have for the 2011 and 2013 deadlines. "As they're designing they use meaningful use as a checkpoint, for tweaking," he says.

Another strategy might be to accelerate an ambulatory EMR for community physicians to create a community benefit around linking physicians so they can report on episodes of care and report on quality. "In this case," says Williams, "they've used meaningful use deadlines as an opportunity to accelerate and make a bold strategic move to an ambulatory EMR."

Yet another organization may use meaningful use as a set of data points that help paint a bigger picture to view how their dollars balance out across the enterprise.

Some organizations are so busy in the middle of an implementation that they've had trouble stopping to work on meaningful use and, Finocchiaro notes, "are waiting for everything to be tied up in a bow—which may be too late."

Estimating your incentive

Williams urges organizations to act. "We believe there's enough directional information to drive effort, particularly on the quality, safety and efficiency side—and some on the HIE side," he says.

Deloitte's estimator tool is designed to be used by provider organizations to quantify the incentives from Medicare and Medicaid and also the potential penalties if they fail to act. "We send out a data request, basically an Excel spreadsheet, for Medicare report cost data. They send it back and we have a team that produces a 10-to-15-page presentation illustrating the total incentives," says Williams. The tool, which can take a week or more to use depending on how deeply a board gets involved in reviewing incentive estimates, breaks down the incentives by hospitals or physicians.

Robert Williams, MD, director, Deloitte Consulting, McLean, Va.

Several organizations are establishing HITECH -specific steering committees that typically involve the CFO, CIO and either CMIO or CMO, and which report to the COO and CEO. "It's that significant—not done within IS," he says, adding that "the penalties are the biggest risk. Some organizations are so far behind that they are finding it not worth the effort for the incentive portion. And within physician organizations it's often doctors who are above a certain age who also feel it's not worth it."

The only solution for some of these facilities may be if a vendor comes forward with a relatively simple solution or one based upon an open-source code.

The Trinity Health solution

If meaningful use can be defined generally as alignment of IT with quality and patient-safety goals, then Trinity Health should offer an instructive example of decision-making toward that end. Trinity Health, a Novi, Mich.-based integrated delivery system that owns or manages 45 hospitals in eight states, is highly regarded for its standardized approach to implementing IT across the enterprise, specifically Genesis, its large-scale initiative launched in 2001 to build a centrally managed, single platform for clinical information management.

TRINITY HEALTH

Novi, Michigan

Paul Browne, senior VP/CIO, Trinity Health, Novi, Mich.

"Our stake in the ground," says Paul Browne, senior VP and CIO at Trinity Health, "is that we want all of our hospitals and employed physicians to meet all of the meaningful use criteria." The organization has formed an internal workgroup charged with tracking evolving meaningful use requirements, mapping them against Trinity Health's levels of compliance and identifying the gaps between.

The task force is comprised of representatives from three groups: advocacy, which includes the health system's Washington, DC, lobbying arm; clinical operations, including the CMIO; and information services, including CIO Browne. Workgroups from each area develop a collective analysis of where Trinity Health is today in both its inpatient and ambulatory areas and where Genesis is expected to be relative to meaningful use compliance dates. "They are charged with making that gap as small as possible," says Browne.

The task force has calculated that if Trinity Health complies with all meaningful-use timeframes it stands to gain $120 million to $160 million in stimulus funds. Once gaps are identified, "that will lead to a discussion of tradeoffs. We're pretty confident that we can meet all the timeframes, but you can never tell for sure," he says.

The 20 percent solution

"We've taken a posture within Trinity that we've laid out an IT plan with Genesis regardless of what the stimulus is," says Browne. "We're continuing to drive 70 percent to 80 percent for Trinity's strategy and 20 percent for the stimulus. The policy makers have really directed the meaningful use requirements at improving quality and safety—not just digitizing the hospital. That's the exact same directive we have. In all the policy discussions we engaged in, IT was not seen as an end in itself but as an enabler. So, philosophically we're aligned," he says.

Browne recalls discussions with David Blumenthal, MD, the National Coordinator of Health Information Technology, in which Blumenthal said: "At the end of the day all hospitals will have some work to do but Trinity Health will have a lot less than most."

The meaningful use task force at Trinity Health works closely with top management via the IS executive steering team, which includes internal non-IS executives, including the corporate CMO and CFO and some hospital CEOs. Browne's responsibility as CIO is to produce an IT plan that's aligned with corporate strategy and approved by the IS executive steering team. So, the recommendations of the meaningful use task force are reviewed by the IS executive steering

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"I've 'advertised' this to our physician and nursing liaisons. Obviously getting signed up on the SI website is the first step. Once they get notices of upcoming events, I think the topics and presenters speak for themselves given the quality. The first step is that communication to the organization, just making them aware that it's available."

—Joel Shoolin, DO, Vice President, Advocate Healthcare

team. A step away is the capital management committee, whose membership significantly overlaps with the steering committee, and which allocates capital across all of Trinity Health.

"Ultimately it will be senior executives making any decisions on tradeoffs we make for HITECH. My perception is that the government set the bar high—they are not easy criteria to meet—but we've been working on it for better part of a decade," says Browne. Still, he acknowledges "We've got some holes," including the need to accelerate bar-code medication administration systems at some facilities. Also, giving patients access to their clinical data was not a big part of the organization's existing IT plan.

The challenge of an ever-changing portfolio

Inpatient, however, is not what keeps Browne awake at night. "The employed-physicians side is our biggest challenge. We need EMRs in place for 1,000 physicians over the next two-and-a-half years. Where the tradeoffs will get interesting is if we acquire a hospital in 2010, 2011 or 2012, how would we respond," he says, to that institution's potential gaps in terms of meaningful use? If a hospital is in an existing Trinity Health market, integration may be desirable. "The tradeoffs—how we deal with Trinity's ever-changing portfolio of hospitals" is still unknown.

Health information exchanges (HIEs) provide another challenge. "HIEs are a very complex area for us," says Browne, noting that Trinity Health is already operational at a half-dozen HIEs around the country. The issue is that HIEs represent a checkerboard of federal, state and local requirements at the same time privacy and security penalties are being strengthened nationally. As a result, Trinity Health has developed a set of "HIE Principles" that it would like an HIE it works with to meet. "If the HIE stores patient information then providers should be able to audit how that information is stored and secured because the penalties come back to providers," says Browne.

Despite the complexities and the rewards, health delivery organizations should maintain some equanimity regarding the stimulus. "It's a mistake to just chase the money," he says. "It's really important for organizations technology-wise to support their own strategies and then overlay that with the stimulus and meaningful use opportunities. It would be a mistake to base IT plans strictly on the stimulus, partly because these requirements will be loose for awhile."

A view from CSC

How health delivery organizations respond to meaningful use is a high-stakes decision.

"This is a make-or-break, succeed-or-fail issue in the next five years," says Erica Drazen, managing partner in CSC's Emerging Practices arm based in Waltham, Mass. "The group that should be in charge is the executive committee with board participation. If you have to form a special new IT committee, you're missing the boat. These aren't IT projects. Meaningful use is linked to national goals" of quality and safety, she says.

Tactically, an integrated delivery network will be held responsible for demonstrating meaningful use throughout the enterprise, not just for certain hospitals. Health delivery organizations that have looser affiliations, however, may be able to pick and choose facilities. The key, Drazen says, is to determine first which sites present the biggest gap burden and second, where does the organization reap the biggest reward for HITECH.

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continued on next page

Erica Drazen, managing partner, Emerging Practices, CSC, Boston

That said, health systems should emulate the kind of delivery models that meaningful use and HITECH aim to encourage, in particular the accountable care organization and the medical home. "When you look at where finance reform is going," says Drazen, "it's toward the accountable care model, where an organization agrees to be accountable for the care of an individual for a fixed fee, and the medical home, which is virtually the same concept without the hospital. These initiatives are like P4P on steroids."

Next to tackle for meaningful-use is the issue of connectivity, which is rife with interpretation. "This idea of connectivity—connecting the communities—really comes down to linking all the providers who are taking care of communities of patients. It's not about a Minnesota patient getting in a car wreck in Arizona and needing their medical records from home, which is pretty rare," says Drazen. An organization like Peace Health, for example, with facilities in Alaska, Oregon and Washington, should focus on connecting physicians and hospitals within each community before they worry about connecting between states: connectivity within logical clusters like Eugene, Ore., and not between it and an Alaska community, for example.

Again, connectivity should be viewed within the context of how it helps to achieve significant quality and efficiency goals for a population of patients.

Chronic disease

"Let's not forget that if we're focusing on what we need to do to achieve better care for patients at lowest cost, chronic care management is key. Chronic disease accounts for 70 percent of the cost of care. We know we will have to fix that cost," she says. While that's the long-term winner, in the meantime health systems can focus on connectivity solutions like admission and discharge optimization, being able to send core information around the community and identifying which patients suffer from chronic disease.

"The good news is that the meaningful use criteria are all heading in this direction," says Drazen.

The meaningful use incentives provide a base payment then an additional payment for each admission up to a ceiling. So, if a hospital is close to meeting meaningful use criteria, invest in it first, especially if it's a big facility. As a system it's wiser to focus on the hospitals that are closer to compliance in order to get the money because you can use that money to fund other desirable initiatives. "The important thing is getting the stimulus money sooner than later," says Drazen.

The prospect of some hospitals not investing in efforts to meet meaningful requirements may well guarantee them a penalty bigger than the federal one—their demise—she says; they will not be able to participate in future delivery and financing models without IT.

There's enough industry experience with CIS implementations at this point to understand how to implement sucessfully. "These aren't experiments anymore. CPOE has been successfully installed in academic medical centers. Fletcher Allen Healthcare implemented an EPIC inpatient system in only 15 months, so why can't anyone else? For every gap a

continued

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- Mitch Morris, Deloitte Consulting, Costa Mesa, Calif.
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- Joel Shoolin, DO, vice president, Clinical Information, Advocate Healthcare, Oak Brook, Ill

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hospital may have in terms of meeting meaningful use, somebody else has done it well, whether it's providing PHRs or understandable discharge summaries to patients, implementing CPOE or closed-loop medication management."

Organizations like Scottsdale Institute become even more important as the need to share such best practices accelerates.

Memorial Hermann

"Everybody involved in healthcare IT should be grateful the federal government has finally taken note of the value of clinical IT," says Michael Shabot, MD, senior VP and CMO at Memorial Hermann, an 11-hospital system serving the greater Houston area. "You have to be happy about that. It's the recognition of decades of work, including that by Scottsdale Institute, AMIA and AMDIS," he says.

"Everybody involved in healthcare IT should be grateful the federal government has finally taken note of the value of clinical IT."

"The bad news is that, now that it's on the table with stimulus and meaningful use," he says, "what do healthcare institutions do about it? These are tens of millions of dollars in IT investments—we have $120 million in our current clinical system alone, Kaiser has $3 billion and still counting. We don't make multi-million-dollar investments without multiple-year plans. Do you alter your plan because you now have to schedule a system implementation for completion by 2011 that may not have been planned until 2013?"

While it may sound easy to *not* let the stimulus money pass you by, trying to exploit the opportunity involves serious systems, interfaces and strategic plans that may focus on hardware one year, software another and training yet another. "It isn't simple to interrupt your multi-year schedule," he says, adding that although there are significant financial incentives in the stimulus, they pale in comparison to the overall expense of the implementation.

MEMORIAL HERMANN

Michael Shabot, MD, senior VP/CMO, Memorial Hermann, Houston

Another factor is the involvement of multiple groups such as physicians, nurses, pharmacists and others involved in the care team. "You can't change culture in a day," says Shabot. "Can you move the medical staff that quickly? Can nurses and others absorb these changes in the midst of many other non-IT initiatives? Those are the real issues."

High-tech personnel shortage

Hospitals can be grouped, he believes, into two camps: 1) SI members and their ilk which have a plan in place, and 2) the majority of hospitals, which lack a strong clinical IT plan and continue to use paper for functions like nursing charts and physician orders. If, for the sake of argument, 3,000 of these mainstream hospitals decide to go for the stimulus—and even had the money upfront to invest in the effort—they can't all be installed in time to meet the meaningful use deadlines. "This requires a highly-trained technical workforce and there aren't enough folks like that out there," says Shabot.

Earlier this month, Memorial Hermann had just its second meeting of its 20-person meaningful use work group, which took the latest guidelines and with the help of a spreadsheet began mapping those requirements to the organization's existing and scheduled capabilities, addressing the questions:

1. Do we have the capacity?
2. Do our vendors have the capability?

3. Is it in our timetable?
4. If not in our timetable, can we do it?

"We need that information in hand in order to size the effort and estimate the resources required in hardware, software and personnel," says Shabot. Memorial Hermann uses a rolling implementation strategy so some hospitals are already doing CPOE and some not.

This ad hoc, stimulus-bill-readiness work group includes representatives from clinical operations and management (CIO David Bradshaw) as well as the hospital CMIO, ambulatory CMIO, CMO Shabot, system pharmacist, system nursing executive and system exec for quality and safety.

"We're implementing physician order entry one hospital at a time, every few months," says Shabot. It's not just a question of timing but also resources. "Unless you hire more people, you can't just add a whole bunch of new work," he adds.

Shabot refers to "the famous matrix," HHS' updated meaningful-use-guidelines document (http://healthit.hhs.gov), to illustrate an example of how complex it can be to fully respond to meaningful use: identification of high-risk medications for the elderly using the Beers Criteria. "If it's something our vendors don't currently provide, do we interrupt the work of our clinical data warehouse group to isolate these medications for reports or alerts? This is just one of 39 meaningful use measures. We have to make an active decision. Do we do it and, if we do, what do we have to move back in time?"

Funding nightmare again

Projects that require funding beyond what's already been allocated would have to go through the executive council at Memorial Hermann. "Whether you're a large health system like us or a small hospital, the real issue is where is the extra funding going to come from? More than half the hospitals in the country operated in the red last year. Where are they going to get capital? They'll spend millions for years before they get their funding back," he says. Hospitals also have to have a certain amount of cash on hand to meet their bond requirements, so even if they do have cash to spend, they run the risk of paying higher interest rates.

"Then, in 2015 you're going to have to pay penalties if you haven't met meaningful use. A lot of mainstream hospitals are between a rock and a hard place. SI members are very select in terms of use of IT, but the percent of hospitals across the country that have CPOE at all is very small. Even for us the decisions are non-trivial. Internally we want to meet the meaningful use goals, but not for financial reasons. Why have we already invested $120 million? Because of quality, safety and efficiency."

Conclusion

In the evolution of healthcare IT, you might characterize the different stages by the buzzwords that rang out in the trade press and conferences during that time. Client server, network backbone, wireless, RFID and CPOE come to mind. Clearly, today's buzz words are "meaningful use." The difference between these current buzz words and the ones before, however, is as big as the gap that some hospitals may find themselves in if they fail to invest in meaningful use.

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