

# Advancing Excellence in Patient Care

## Health Information Technology

### Background

Every day, the women and men of America's hospitals strive to improve the safety and quality of care they provide. Research has shown that certain kinds of health information technology (IT) – such as computerized physician order entry (CPOE), computerized decision support systems, electronic health records (EHRs) and bar coding for medication administration – can limit errors and improve care. Health IT can also be a tool for improving efficiency. Efforts are underway across the country in hospitals big and small, rural and urban to adopt health IT.

To provide needed funding for EHRs, the *American Recovery and Reinvestment Act (ARRA)* authorized the Medicare and Medicaid EHR Incentive Programs, which begin in fiscal year 2011. These funds, however, will be available only to hospitals that can demonstrate they are “meaningful users” of EHRs. The Center for Medicare & Medicaid Services (CMS) recently proposed a very ambitious definition of meaningful use, which likely would limit the flow of funding to most hospitals. The AHA provided extensive comments on the proposal advocating an alternative approach that would reward incremental progress over time.

Apart from the Medicare and Medicaid incentives, the Department of Health and Human Services (HHS) has developed grant programs to promote use of interoperable EHRs, supported by \$2 billion in ARRA funding. HHS has begun programs to develop the health IT workforce, provide technical assistance on EHR implementation, support innovations in local communities and continue working toward the vision of a national health information network. Portions of ARRA funding also have been awarded to states to facilitate a non-proprietary health information exchange that adheres to national standards. HHS continues to lay the groundwork for a national health information network.

### AHA View

The AHA has been a longstanding advocate for health IT, specifically the rapid adoption of EHRs and the use of national standards of interoperability. In fact, these elements are essential to the AHA's *Health for Life* – a framework to improve America's health and health care.

Shared health information will allow clinicians and patients to have the information they need to promote health and make wise decisions about treatments. Health IT standards adoption and greater interoperability will facilitate the sharing of such information, but only if there is a proper foundation. Several key definitions are essential to that foundation. They include:

- A definition of meaningful use that includes broad objectives and advances widespread health IT adoption;
- A definition of hospital-based eligible professional which allows more physicians to qualify for EHR incentives, commensurate with congressional intent; and,

- A definition of hospital that allows each hospital within a system to be evaluated and eligible for EHR incentive programs individually.

Also key to a proper foundation is inclusion of Critical Access Hospitals in the Medicaid EHR Incentive Program.

**Meaningful Use.** While hospitals have made great strides in implementing health IT, a January 2010 survey found less than one percent reporting that they could meet all 23 of CMS' "meaningful user" proposed requirements. Because of the high costs and potential for disruption of care, many hospitals cannot afford to implement a comprehensive EHR within the next five years.

The AHA believes that the meaningful use criteria and timeline proposed by CMS are unrealistic. The AHA supports an alternative approach that recognizes the efforts currently underway in hospitals, provides operational and strategic flexibility, and ultimately results in the shared national vision of an e-enabled health care system. The AHA approach will lead to much broader adoption rates of successful EHR systems across the vast majority of hospitals in a sustainable timeframe because hospitals would have more certainty, predictability and flexibility to address both institutional and local, community priorities.

**Certification.** For hospitals to achieve effective use of health IT systems, it is essential that IT vendors produce systems capable of fulfilling the requirements for meaningful use. Certification policy should actively reinforce a clear distinction between the responsibilities of health care providers and the responsibilities of product vendors. Thus, the certification process for vendors and hospital meaningful use requirements are interdependent, and the regulatory bodies – the Office of the National Coordinator for Health Information Technology (ONC) and CMS – must work collaboratively. Similarly, the implementation timeline required in both rules must recognize this interdependence. Because of the lead-time needed to implement complex EHR systems, vendor product certification should be completed prior to providers' meaningful use deadlines. The result should be a fully functioning and effective electronic infrastructure that supports busy clinicians in the delivery of safe, high quality, efficient care. Ultimately, the time frames required in ARRA are very aggressive and the AHA believes that a "grandfathering" policy for certification is needed to ensure that EHR incentives can begin in 2011 as Congress intended.

**Hospital-based Eligible Professional.** Encouraging hospital staff to use health IT is key to its broad adoption. Therefore, the AHA is concerned with CMS' proposed approach which inappropriately excludes eligible professionals from health IT incentive payments. The AHA recommends defining a hospital-based eligible professional as a pathologist, anesthesiologist, emergency physician, hospitalist, intensivist or neonatalist for whom at least 90 percent of their billed claim lines have a site of service of the inpatient, outpatient or emergency department.

Additionally, it is critical that CMS allow professionals to petition for a change in their hospital-based status when there is a change in their organizational affiliation. Absent CMS clarification, the AHA secured a legislative fix through the Senate “jobs” bill, the *American Workers, State and Business Relief Act* (H.R. 4213), which ensures that physicians who practice in hospital-owned outpatient centers and clinics qualify for the stimulus legislation’s health IT incentives. A similar provision was included in H.R. 4851, which passed the House in March.

**Hospital Definition.** A barrier to widespread EHR adoption is the narrow approach CMS proposed to limit health IT incentive payments for hospitals that are part of a system. The AHA urges CMS to use a multi-pronged approach that allows a “hospital” to be defined in ways that acknowledge the varied organizational structures of multi-hospital systems, including by a distinct CMS certification number, a distinct emergency department or a distinct state hospital license.

The AHA has outlined many changes needed in the Medicare and Medicaid incentives programs – definition of “meaningful use,” definition of a hospital-based physician, definition of a hospital, certification grandfathering and more. Members of Congress agree and 249 House members joined Reps. Zack Space (D-OH), Elliot Engle (D-NY), Michael Burgess (D-TX) and Cliff Stearns (R-FL) in a March 2010 Dear Colleague letter urging CMS to adopt changes and create a more reasonable approach to implementing the Medicare and Medicaid EHR incentives programs. Twenty-seven senators joined Sens. Amy Klobuchar (D-MN) and Orrin Hatch (R-UT) on a Senate companion letter.

A final rule on meaningful use is expected in June, as are final regulations on certification requirements and the federal certification process. The AHA continues to advocate for a series of needed changes in both the proposed meaningful use regulation and the proposed certification criteria and process that are needed to enable hospitals to benefit from the Medicare and Medicaid EHR Incentive Programs.

In addition, the AHA continues to work on the following health IT issues:

- *Easing the Coding Transition* – In 2009, HHS mandated adoption of new International Classification of Diseases (ICD) standards, or ICD-10. This update to the outdated ICD-9 coding system was long overdue, and the AHA strongly advocated for the change. While the deadline for implementation is not until 2013, the AHA has already issued guidance to help hospitals prepare for this significant and complex transition. Many provider and health plan databases and applications will be affected; therefore, transitioning will require careful planning and coordination of resources. The AHA is pleased that the health reform bill included new requirements to facilitate claims attachments that will lessen the burden on hospitals to comply with insurer requests for clinical information not contained elsewhere in the claim standard.

- *Ensuring Patient Privacy* – The AHA is concerned about the privacy provision in the ARRA that expands providers' responsibility to account for disclosures of personal health information. Under current law, hospitals must account to patients for disclosures of their personal health information, but not for disclosures made in the course of treatment, payment and health care operations – the most frequent disclosures. The ARRA expands the “accounting for disclosures” responsibility to include disclosures for treatment, payment and operations purposes, which significantly increases hospitals' reporting burden. However, the ARRA shortened the look-back period so that hospitals will be required to account for disclosures for only three years, instead of the current six-year requirement. Hospitals with new electronic systems will have to incorporate this expanded reporting requirement by 2011, while those with existing electronic systems will have until 2014 to modify their systems. The ARRA allows the HHS Secretary some flexibility to delay these effective dates. Given all of the other requirements hospitals are trying to meet to be meaningful users, the AHA urges that the HHS Secretary delay the expanded reporting requirements to 2014 for all hospitals.
- *Anticipating Workforce Growth* – With the rapid growth of health IT, it is estimated that demand for health IT professionals will quickly outpace supply. In response, HHS has announced several initiatives that promote health IT workforce development, including grants to support university programs that rapidly train health IT professionals and to fund curriculum development.
- *Advocating for Patient Safety* – The issue of how to match patients with their medical records remains unresolved despite the continued push for interoperability on a national scale. The AHA continues to press for a resolution, and to recommend the creation of a nationally unique identifier system to connect records and to ensure that hospitals and physicians have the best information available when providing care for each patient. Such a system would facilitate efforts to increase the safety and quality of care given to patients.

Similarly, a system of unique identifiers for medical devices would increase efficiency and add an element of transparency to the medical device industry by providing basic, standardized information on all medical devices. The Food and Drug Administration finished a pilot test of a system for unique device identifiers for medical devices and is expected to introduce proposed rules on the issue this year. The AHA continues to advocate for a uniform system of identification in order to streamline supply chain efficiencies, reduce costs and improve patient safety.