Looking at the Meaningful Use Mountain: An REC Perspective

March 11, 2014 by Rajiv Leventhal

Stage 2 of meaningful use brings unprecedented challenges and difficulties upon provider organizations. Extending MU deadlines and pleading for more flexibility have been the hot-button issues surrounding the incentive program, but additional problems exist as well. As these organizations advance beyond the earliest phases of meaningful use reporting, they quickly realize how tough it can be to track the details in a process that is constantly changing.

The Indiana Health Information Technology Extension Center, also known as Purdue Healthcare Advisors (PHA), is one of 62 regional extension centers (RECs) established by the Office of the National Coordinator for Health IT (ONC). PHA provides services to assist hospitals and ambulatory organizations with their meaningful use needs, and has worked with more than 90 hospitals and 3,000 physicians on meaningful use compliance. Two staff members from PHA—Randy Hountz, principal of operations and Natalie Stewart, meaningful use managing advisor, spoke with Healthcare Informatics Assistant Editor Rajiv Leventhal at the Healthcare Information and Management Systems Society (HIMSS) conference in Orlando, Fla. last month about the challenges and concerns their clients have with meaningful use, and overall industry trends when it comes to the program. Below are excerpts of that conversation.

Hountz: How are you helping your clients attest to meaningful use?

Stewart: SA Ignite’s MU Assistant product relieves provider organizations of duties such as keeping track of eligibility, payment year, meaningful use stage, and program type—tasks that can undoubtedly amount to a full-time job. It’s the TurboTax of MU attestation. Many organizations have providers that are in different years of the program, and it becomes challenging to track that on a spreadsheet. This software provides tracking, tells them if they’re compliant or not, and what their problem areas are.
Hountz: They key is, you need to be able to see the data. We had a client who would have missed getting folks to meeting MU last year, because their EHR didn’t make it easy to see data at a glance. At a glance, you couldn’t see if a provider wasn’t making it. We want to be able to get people to see that. Right now, many places are using Microsoft Excel to get the data out and track everything, including metrics. There are all these colors and dots—it’s brutal!

HCI: What are the biggest challenges organizations are having when it comes to MU?

Stewart: In terms of objectives, the patient engagement 5 percent view/download/transmit piece has been a challenge. And clinical decision support, transitions of care, and encryption are the other main obstacles that we’re seeing. The security requirement is incredibly vague.

HCI: That certainly covers a lot. Should I have asked what part of MU is not challenging instead?

Hountz: No, it’s really those four things. The process is immature with transitions of care. How is your EHR going to handle Direct [messaging]? You have to have the capabilities of Direct, but do you have your own Direct inbox? Then, as a provider, how do I know what the Direct mailbox is of the Dr. Smith who I am referring to? Is my EHR providing that service and do they talk to each other yet? That world is still incredibly grey at a granular, detailed level.

HCI: What makes the patient engagement part of this so particularly challenging?

Stewart: Well, even though 5 percent is a small percentage, you still need that to meet that objective. Engaging patients in order to make them be a partner in their care and have them get to a point where it’s more than just meeting a threshold is tough. The larger scale picture is to make it advantageous to everyone involved and have them be part of that care process.

Hountz: Also, selection of patient portals is key. We deal with a lot of midsize hospitals that often cannot afford an Epic or a Cerner. And they have disparate EHRs for inpatient and ambulatory needs. They’re stuck, and they would like to pick one or the other. Many are actually looking for a third-party vendor. We don’t know what the right vendor is, but we do know what the right number is, and we tell them that. If you have patients who are in a hospital setting and an ambulatory setting, and you say you have two portals, you have the wrong number. It can only be one.

But organizations are just starting to get there with portals in terms of selection, integration, and the workflows. It’s just all new. We’re working with hospitals and they want us to help them with figuring out who collects email addresses. And most people would say, “How hard could that be?” It doesn’t work that way in a hospital system—the person on the floor might not be able to see the registration side, so they might not know about that data piece. You hate to ask the patient 17 times for something they have given you. Providers need to be comfortable with patient engagement, and the process is immature.
*HCI:* Provider organizations have been pressing for more flexibility when it comes to MU. What are you hearing about that?

*Hountz:* Really, it's just all too much. We're asking all these organizations to do all their revenue cycle, ICD-10, Stage 2, PQRS (physician quality reporting system), be an ACO (accountable care organization) and PCMH (patient-centered medical home), and be HIPAA-compliant. It's initiative overload and it leads to fatigue. I empathize with them. So some organizations say they need help and their heads are down. You have to get it to the point where these incentives align, but they don't yet. PQRS and ACO measures don't align with meaningful use yet. Some of it does, but not all of it. It will be years, but it will be warranted.