VISTA Community Meeting
Day Two: January 15, 2011
Morning Session

# Topic: IHS Meaningful Use

*Presenter*: Howard Hays, MD

[Note: Dr. Hays did not attend the conference in person, but joined the morning session via conference call.]

Dr. Hays introduced himself and expressed regrets that he could not join everyone at the conference. He inquired about the mix of people in the room and how many of them were familiar with WorldVistA. He will proceed on the assumption that the group understands what the IHS (Indian Health Service) is, and what Meaningful Use (MU) is and what the requirements are.

Dr. Hays introduced the term I/T/U, meaning Ihs/Tribal/Urban; i.e., the full scope of services at IHS. There are 29 IHS hospitals, 16 Tribal hospitals, and over 900 Eligible Providers. Nothing in the law says that federal agencies are excluded from Meaningful Use incentives, so IHS is going after them.

Incentives: $44,000 per provider (Medicare) or $64,000 per provider (Medicaid)

Ihs OIT role in meeting MU requirements:
Produce a certified EHR for ambulatory/inpatients
Analyze requirements and criteria
Produce comprehensive training and literature
Develop reporting capabilities in RPMS
Continue to develop and advance RPMS

Rpms EHR certification:
Gap analysis: some significant gaps, and some more nuanced requirements.
Example: there is a problem list, but there is a requirement that the list say explicitly that the patient has no problems, rather than an empty list, so a change has to be made.

Rpms development:
Registration: race/ethnicity, preferred language, preferred method of contact. Ihs had not previously bothered with questions about race, because of the nature of their mandate, but now they'll need to.
Pcc: problem list, Health Factor changes (i.e., smoking information)
Ehr: problem list, CCD viewer
Syndromic surveillance export

Q: Had you heard that they changed that requirement? It sounds like you're done.
A: Yes, we're pretty much done, although it hasn't been implemented yet.

Electronic patient education materials
MPI, NHIN – CCD and CCR Retrieval
Personal Health Record portal

Q: Did you know that the ONC [Office of the National Coordinator] has standardized on CCD?
A: For stage one?
Q: No, later. Just to let you know.

MU Objectives and Reports:

MU Clinical Quality Measures and Reports
The providers get to decide which ones, but of course the vendors have to be able to do all of them. We objected to that, and we suspect some other people did. They relaxed the requirement for ambulatory, but we still need to be able to support all the hospital ones.

Certification:

ATCB contract issued—InfoGard
Certification database established, internal testing ongoing

After testing, IHS plans to release enhancements (March). Some are fairly significant in terms of the changes required in business practices.

Challenges:

Final Rules do not explicitly require codesets such as SNOMED and RxNorm, but many quality measures are based on these codes, which requires mapping and substitutions.
Fields such as "last known well" and medication administration time, which don't exist at all in RPMS, so we have to figure out a kludge.

Q: Have you been reporting any of these issues to the ONC?
A: Yes, both formally and informally. And I think that our comments have been taken into consideration. But we've been reporting quality measures for years, and some of their logic is so vague it's just crazy-making.

Vague or ambiguous measure logic:

Summary of Care records (C32 is a step backward from what IHS uses).

EHR cost calculations are a challenge for a public facility. Costs for federal sites are being paid because we're part of the federal system, so calculating costs is a challenge.
Determination of "charity care" volumes also works differently from in a private-sector facility.

IHS Support for MU

Analysis of MU requirements

Area MU conferences and training

Integration of MU with EHR deployment

Publication of MU incentive estimates

MU website with training power points and links to WebEx training sessions

Contract to hire MU consultants in all areas

NIHB (National Indian Health Board)

NIHB received a Regional Extension Center (REC) grant for EHR implementation.
Their "region" is nationwide.

They can support tribal programs; so Tribal programs can align with their local/state REC or the NIHB REC.

NIHB REC isn't allowed to specify a vendor, so they aren't pushing RPMS, but RPMS is available through them.

Dr. Hays briefly demonstrated IHS's Personal Health Record portal.

Q: I was surprised to find that some [IHS] clinics are going with other EHRs. Isn't that counterproductive?
A: That's kind of a loaded question. A fundamental principal in the federal government is that Tribal programs have complete autonomy. They can best determine what their needs are, and how best to address them. It forces us to produce things that the tribes want to use. I believe in self-determination, but I also believe in RPMS. I think it works well in Indian country, and meets all the reporting requirements. The problem is, we don't have the resources for marketing and fancy brochures; the playing field is not level in that regard. We have to concentrate on creating a strong product. It does affect us; if a tribe chooses a private-sector product, we lose money.

Q: To what extent does RPMS support oral health care? The link between medicine and dentistry?
A: RPMS has had a dental module for some time. Our dental program has determined that it is not sufficient for their needs. They made the decision to license a third-party software, Dentrix. We have developed an interface between RPMS and Dentrix.
Q: To what extent do those modules support pediatric dentistry and periodontal care?
A: That's out of my scope; I can't answer that.

Q: Will IHS be pursuing separate certifications or a dual certification?
A: To the extent that the criteria overlap, we will only be tested once. However, we will be listed as both.
Q: So you're going for two products?
A: Well, we're paying for two certifications.

Q: Did you look at DRM (Dental Record Management), which was written to interface with VISTA and RPMS?
A: I personally saw it, but I don't know whether the dental program considered it. They evaluated six different products, and actually installed the products and used them at different test sites.

Q: In future, if a tribe picks a commercial EHR, they then have to worry about certification?
A: Certification is the vendor's problem. If a tribe buys an EHR product from a vendor, they need to make sure it's certified. In terms of Meaningful Use, our MU program is not vendor-specific. Most users of the program will be RPMS users, but we don't have it as a requirement for the trainings and materials. Sites that chose non-RPMS products are responsible for using those products for MU.

Q: Isn't information-sharing superior among RPMS sites than between different-vendor sites?
A: No. We actually haven't had a lot of sharing among sites. VA has had this for several years, but we have not had that. So I don't think sharing is necessarily going to be better among RPMS sites.

More information is available at http://www.ihs.gov/recovery.