February 1, 2013

SUBMITTED ELECTRONICALLY

Maria Harr
Government Task Leader
Centers for Medicare & Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244-1850

ATTENTION: CMS-3278-NC

Re: Request for Information on Hospital and Vendor Readiness for Electronic Health Records
Hospital Inpatient Quality Data Reporting

Dear Centers for Medicare & Medicaid Services:

Trinity Health appreciates the opportunity to respond to the “Request for Information on Hospital and Vendor Readiness for Electronic Health Records Hospital Inpatient Quality Data Reporting,” as published by the Centers for Medicare & Medicaid Services (CMS) in the Federal Register on January 3, 2013. In this letter, we offer reactions and recommendations to the electronic health records (EHR) electronic reporting request for information (RFI).

Trinity Health is among the largest Catholic healthcare systems in the country. Based in Livonia, Michigan, we operate 47 acute-care hospitals, 432 outpatient facilities, 32 long-term care facilities, and numerous home health offices and hospice programs in ten states—California, Idaho, Illinois, Indiana, Iowa, Maryland, Michigan, Nebraska, Ohio, and Oregon. Our hospitals and clinics employ nearly 3,400 physicians, and we work with another 7,600 physicians through our open medical staff model.

As one of the largest hospital systems to attest to Stage 1 Meaningful Use, Trinity Health is in a unique position to provide feedback on the electronic reporting RFI. Trinity Health is already preparing to meet Stage 2 Meaningful Use, and has made strategic investments exceeding $400 million to connect 36 community hospitals (including 10 critical access facilities) with an integrated health information technology platform, including a common EHR and clinical decision support tools. During peak hours, more than 4,000 clinicians and staff in the Trinity Health system use the Cerner Millennium® healthcare computing platform to electronically manage medication administration, provide clinicians with access to evidence-based clinical data, and identify opportunities for clinical, operational, financial, and regulatory improvement. Each day, our system manages more than 1.1 million orders transactions. Trinity Health's EHR contains more than 10.5 million patient records, making it one of the largest comprehensive EHR-based data repositories in the United States.
Trinity Health, as supported by our Chief Information Officer and Chief Operating Officer, fully endorse the objectives of the Inpatient Quality Reporting and EHR Incentive Programs. The programs have motivated thousands of hospitals and providers to adopt EHR platforms, engage patients in their healthcare, and provide better care and smoother transitions. However, to achieve efficiency gains from the electronic reporting of clinical quality measures (CQMs), we recommend that CMS reduce the administrative burden associated with reporting CQMs across the range of quality reporting programs (e.g., Medicare EHR Incentive Program, Hospital Inpatient Quality Reporting Program, and Hospital Value-Based Purchasing Program). Already providers have established specific processes to collect and report on quality data for numerous programs—each of which has different measures, specifications, and submission requirements. CMS can reduce this reporting burden by aligning the specifications for quality measures and by eliminating duplicative reporting requirements across programs.

In this letter, we offer our recommendations for supporting hospitals and vendors as we move further toward comprehensive electronic reporting of CQMs. We hope that these comments will help to expand and enhance EHR use, improve patient care, reduce costs, and increase quality of care.

Our comments on the following pages focus on eight specific questions raised by CMS in the RFI and are informed by our decade-long experience in EHR implementation. We support the goals of quality reporting and believe our perspective as an early adopter and advanced user of EHRs in a range of settings and communities will be particularly helpful as CMS continues to move toward electronic reporting across all programs. If you have any questions about our comments, please feel free to contact me at 734.343.0824 or wellstk@trinity-health.org.

Sincerely,

Tonya K. Wells
Vice President, Federal Public Policy & Advocacy
Trinity Health
Responses to Specific Questions

1. **How do hospitals and vendors perceive the alignment of EHR-based reporting and hospital quality reporting programs? What are the foreseen benefits and challenges?**

Trinity Health believes that aligning CQMs and their related specifications across programs is crucial for reducing the administrative burden on hospitals. At present, hospitals face significant challenges in addressing the discrepancies in specifications between manual and electronic reporting of the same measures. For example, at many of our hospitals, staff members collect patient arrival data manually only after initial clinical interventions. This process can create discrepancies in manual versus electronic reporting because treatment times (e.g., time stamp on electrocardiogram) could precede “patient arrival time” and produce errors in electronic CQM calculations. While providers have identified ways to spot and correct for such discrepancies prior to computing CQMs for manual reporting, the electronic reporting environment will not support such modifications. Instead electronic reporting of CQMs with current specifications will require providers to overhaul workflows to capture data in the order of operations (e.g., patient arrival time documented before starting patient treatment), sometimes at the detriment of patient care. As such, we recommend that CMS ensure that measures specifications align across manual and electronic versions to ensure greater similarity in the data generated by either calculation.

Ultimately, to ensure that hospitals can realize the potential efficiency gains, we recommend that CMS align measures and their specifications, selecting only CQMs that hospitals can report on electronically. In the meantime, we recommend that CMS accept electronic CQM reporting by eligible hospitals (EHs) for the EHR Incentive Program as meeting the requirements for other quality reporting programs. CMS has made a similar allowance for eligible professionals via the Physician Quality Reporting System, and we believe that doing so for EHs will enable all providers to focus on implementing the electronic reporting of CQMs. By migrating to simultaneous electronic reporting for all programs, CMS will enable providers to focus on transitioning physicians to documenting required data elements electronically in a discrete format to support measure reporting.

2. **Do hospitals and vendors envision being able to meet the criteria for reporting CQMs electronically for the EHR Incentive Program as set forth in the EHR Incentive Program—Stage 2 final rule and any related guidance issued? If not, what are the issues in meeting the requirements and what additional information is needed?**

We anticipate being able to meet the EHR Incentive Program criteria for reporting CQMs electronically, and we have selected January 1, 2014 for our internal start date for Stage 2 Meaningful Use, Year 1 reporting. However, we are concerned about our ability to drive the universal adoption of documentation templates necessary for electronic CQM reporting. With the short timeframe between installation of the 2014 edition EHR and our planned reporting period, we are concerned about gaps in documentation and low physician adoption rates. Those issues may cause CQM performance levels to be lower than reality (e.g., clinicians may forget to document critical variables despite having performed those functions, thereby diluting performance levels). We recommend that CMS encourage providers to focus on driving towards electronic reporting, however incomplete (due to documentation gaps) or
inaccurate (caused by a failure to consistently document care practices) as opposed to requiring providers to invest resources focused on ensuring data accuracy and completeness for electronic reporting.

CMS offered a similar reprieve in Stage 1 by not penalizing providers if parts of the hospital were not automated and hence their data was not available in the EHR for CQM reporting. We believe similar flexibility for Stage 2 would enable providers to focus on migrating to electronic reporting as opposed to diverting resources for abstracting data from charts for electronic documentation.

3. **Is the hospital planning to adopt EHR technology that has been certified to the 2014 Edition EHR certification criteria during or before calendar year 2014?**

Our EHR vendor, Cerner, expects to have the updated technology available for installation in our hospitals by May 2013. Following installation, we will reconcile the data collection methods used by our hospitals and physicians, train staff on processes to collect new data elements, and validate system ability to generate CQM reports. As a result, we anticipate being able to begin reporting in the second quarter of fiscal year (FY) 2014.

4. **Is the hospital aware of the payment adjustments authorized under the Health Information Technology for Economic and Clinical Health Act beginning in FY 2015 for failing to demonstrate Meaningful Use under the Medicare EHR Incentive Program?**

We are aware of the payment adjustments—and incentive payments—associated with the Medicare EHR Incentive Program. As stated previously, all 36 of our hospitals have successfully attested to Stage 1 Meaningful Use and are in the process of preparing to attest to Stage 2.

5. **Is the hospital planning to electronically report CQM data—specifically venous thromboembolism (VTE) and stroke (STK) and emergency department (ED) measures—under the Medicare EHR Incentive Program in FY 2014?**

Trinity Health is planning to electronically report on CQMs, including VTE, STK, and ED measures, in FY 2014. However, we are concerned that we will be unable collect and submit quality data for 100 percent of our patients via electronic reporting. We will likely not complete our ongoing process of reconciling data collection methods and migrating to electronic documentation system-wide by FY 2014, which may leave gaps in the data that we report. Since gaps may remain, our data for the EHR Incentive Program may differ from the manual data collected for the Hospital Inpatient Quality Reporting program. For that reason, we again recommend that CMS align the manual and electronic specifications to reduce dissimilarities, and in the meantime, treat EHs that attest to the EHR Incentive Program as having met the requirements of other quality reporting programs.

6. **Is the hospital already participating in or planning to participate in the 2013 Medicare EHR Incentive Program Electronic Reporting Pilot for Eligible Hospitals and Critical Access Hospitals? If not, what barriers prevent the hospital from participating?**
We are not currently participating in the EHR Incentive Program Electronic Reporting Pilot. Although we recognize the importance of the pilot and the potential efficiency gains from electronically reporting CQMs, we have invested our resources in perfecting Stage 1 requirements and preparing for new Stage 2 requirements while we await our vendor’s updated documentation and reporting modules.

7. **Will the hospital use a third party to report quality data required under the EHR Incentive Program?**

At this time, we do anticipate using a third party to assist in the submission of the quality data. We currently use a third party when reporting measures to The Joint Commission and CMS; however, we plan to use Cerner, once they have met the 2014 certification requirements, to support us in generating the data used for CQM reporting under Stage 2 of the EHR Incentive Program.

8. **Are there operational challenges to electronically reporting quality data? If so, does the hospital have mitigation plans to overcome these challenges?**

Trinity Health anticipates several challenges in electronically reporting quality data. First, we will need to compare measures and their specifications across programs, as well as identify discrepancies and ways to collect additional data elements arising from these discrepancies. We hope to collect once and report across different programs. Second, as we migrate to electronic reporting for all patients (as opposed to reporting based on a sample as done in other quality programs) we will need to redesign workflows to drive greater physician documentation instead of relying on chart abstractors. Third, our ability to implement and drive adoption of electronic documentation templates for CQM reporting is dependent our EHR vendor's ability to provide us with a certified upgrade in a timely manner. We are in the process of addressing these challenges to be prepared to report CQMs electronically starting in 2014.