

Testimony

Of

**Amanda Heron Parsons, M.D., M.B.A.**

**Assistant Commissioner, Primary Care Information Project**

**New York City Department of Health and Mental Hygiene**

before the

**HIT Policy Committee-Meaningful Use Workgroup**

**Population Health Session**

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Good morning Co-Chairman Hripesak and Davidson, as well as members of the HIT Policy Committee's Meaningful Use Workgroup. I am Dr. Amanda Parsons, Assistant Commissioner for the Primary Care Information Project (PCIP) at the New York City Department of Health and Mental Hygiene (DOHMH) and project director for the New York City Regional Extension Center.

By offering incentives in the HITECH Act for the "meaningful use" of electronic health records, Congress created a mechanism to safeguard their intent that this unprecedented public investment result in concrete progress towards policy objectives; measurable improvements in health care outcomes and reduction in costs. Moving physicians to Meaningful Use will help ensure that providers have not only the tools to improve the care of an individual patient but also the data and systems necessary to enact new models of collaborative care to broadly improve population health. The latter will require that public health agencies play a pivotal role in the evolution of the Health Information Technology (HIT) policy, and I'm delighted to have been invited today to present the PCIP's thoughts on the cross section of public health and Meaningful Use.

What I can add to this discussion is our experiences at the NYC Primary Care Information Project and the NYC Extension Center.

By way of brief background, with public funding, we established a master contract with a commercial electronic health record (EHR) vendor a little more than three years ago. As we detailed in a recent Health Affairs publication<sup>1</sup>, we worked closely with the vendor to develop new functionality that supports prevention and population management, including integrated registry functions, point of care decision supports for providers, and automated quality measurement. With our help, more than 2,100 primary care providers in NYC have gone live on this prevention oriented EMR across four hospitals, 29 Community Health Centers, 402 small practices and 1 correctional facility. The Office of the National Coordinator for Health IT has selected PCIP as the Extension Center for NYC and we are committed to ensuring that more than 4,500 providers achieve Meaningful Use by 2012.

We currently have several public health projects underway that I would like to share with you.

- With funding from the Agency for Health Research and Quality (AHRQ), we tracked the increase in documented clinical preventive services across a sample of our practices via retrospective chart review. Our data shows that providers using the EHR with clinical decision support show increased rates of patients meeting

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<sup>1</sup> Farzad Mostashari and Micky Tripathi. "Achieving Meaningful EHR Use: Leveraging Community Structures." *iHealthBeat*. February 10<sup>th</sup>, 2009. <http://www.ihealthbeat.org/Perspectives/2009/Achieving-Meaningful-EHR-Use-Leveraging-Community-Structures.aspx>

prevention goals around antithrombic therapy use, BMI recorded, breast cancer screening, control of A1C, control of blood pressure in patients with and without diabetes and ischemic vascular disease (IVD), control of low density lipoprotein (LDL) in patients with diabetes or IVD and smoking status screening. We did not see an improvement in the number of documented smoking cessation interventions (unpublished data).

- We have developed shared content service with commitment from all major lab companies in New York City. This service provides Logical Observational Identifiers Names and Codes (LOINC)-mapped compendiums to EMR vendors in order to prevent interruptions or errors in CDSS, quality measurement and syndromic surveillance dependent on accurate electronic lab results.
- We have built a bidirectional EMR interface between our Citywide Immunization Registry and PCIP practices, which allows immunization information, documented during the course of routine care, to be transmitted with very low administrative burden. In addition, providers will soon be able to access immunization histories, allowing them not only to see a more complete health profile for the patient but also to do advanced planning like vaccine quantity forecasting.
- We have built a Health Quality Information Network (HQIN) that receives monthly, aggregate provider-level quality measures from three different EMR vendors, which can generate provider and practice quality reports. Currently, more than 300 practices report into the HQIN monthly
- With funding from the Robin Hood Foundation, we deployed a pay-for-performance program that rewards participating providers for each patient that is in the numerator of a quality measure for Aspirin Prophylaxis, Blood Pressure control, LDL control and Smoking Cessation intervention. Payments are higher for Medicaid or uninsured patients, and also for patients with relevant co-morbid diseases like diabetes and ischemic vascular disease. This program is applied to all patients in the provider's panel, giving practices a reason to invest in new workflows that benefit all their patients.
- We have built and are now testing a public health hub that allows us to send informational and/or actionable alerts to targeted providers in our program (e.g., based on a zip code where a disease outbreak is occurring). This hub will also be used to monitor the health of the community, providing useful information to help us respond and adapt to emerging outbreaks or changes in health guidelines.
- We currently receive and analyze daily aggregate syndromic surveillance data from our practices on respiratory, febrile and gastrointestinal illness. This allows us to track and monitor disease outbreaks like last year's H1N1 outbreak.

From our work, we have identified several barriers that could be addressed by HIT policy development including;

- The need for universal adoption of LOINC coding by laboratories for all lab results. Without these LOINC codes, Clinical Decision Support, Quality Measures and syndromic surveillance will be severely limited. ONC should consider requiring EHR vendors to use only those lab compendiums which have

LOINC codes for at least the Meaningful Use and Quality Measures. This market demand may spur the changes necessary to catalyze the process.

- Incentives for laboratory companies to provide at least one bidirectional interface to all practices that need them, regardless of how relatively small their order volume is. Small primary care practices are at a comparative disadvantage to their large, multispecialty counterparts because of the relative low volumes of “inexpensive” tests they order. Given the resources and investments lab vendors have to make to set up these interfaces, it is no wonder that they are reluctant to prioritize small primary care practices. ONC should ask EMR vendors to report back the number of bidirectional lab interfaces they have by lab company, leveraging transparency and cross-vendor/cross-lab comparison.
- The ability for patients to easily move their data from personal health records (PHR) tethered to EHRs to other patient platforms of their choice. Given the revenue potential for secondary uses of data and captive patient audiences, some EHR vendors are reluctant to allow patients to move their data out to other settings like third party PHRs, which runs counter to the notion of patient-centered care. We believe the patient data should not be tethered to EHRs, but rather, should follow the patients where it needs to go as determined by providers and patients, not EMR vendors. Therefore, EHR certifying bodies like the Office of the National Coordinator (ONC) should insist on portability of data out of EHRs and their proprietary patient portals.
- An understanding of the workflow challenges providers face because of the relative rigidity of required documentation necessitated by EMR-derived quality measures. In our own comparisons of data from chart reviews to EMR-derived quality measures, in all cases, providers scored lower on EMR-derived measures due to their documentation workflows. For some measures like smoking cessation screening, the performance on chart reviews was double what it was on EMR-derived measures because data was not where it needed to be for computer calculated measurement. We believe this has significant implications for Stage 3 Meaningful Use and the assessment of provider performance.
- The external stakeholders who may be recipients of data from EHRs are not yet used to seeing forms differ from the paper copies they are familiar with. For instance, we embedded the M11Q form into the EHR to facilitate requests for home care services. From within the EHR, the form pre-populates with patient information, leaving only a few items for providers to fill out. However, entities that receive these electronic M11Qs have noted that the electronically generated version is slightly different than the paper version, and therefore they can not accept them. We encourage CMS and ONC to use their leverage to ensure State policies reflect the need to encourage and inform healthcare stakeholders to focus on content over format, particular in a hybrid world where paper documents will look different than their EHR generated counterparts. For stage 2, we suggest including the increased use of electronic forms (where feasible) as a way to improve care coordination and decrease administrative burden. These could include universal reporting forms, home health services forms and school health forms, to name a few.

- The challenges associated with exchanging information between all health care settings. Currently, our participating providers can eFax patient health information, and soon will be able to leverage a proprietary vendor network to securely exchange health information. However, we need more solutions that allow providers to easily reach across geographic, vendor and business model boundaries so that information can follow the patient in a patient-centric, not business model centric, manner.

Going forward, as we continue to deploy EHRs and help them connect across health care settings, we look to HHS for policies and services that can align incentives between stakeholders, such as:

- Encouraging all practices, regardless of setting, to share information with the patient and, when permitted by the patient, other providers in the care spectrum.
- Given the challenges vendors will have in programming Meaningful Use, establishing a Standardized Meaningful Use certification methodology that leverages a standardized test deck which EMR vendors input and report back their calculation.
- Standardizing scalable Meaningful Use assessment models across vendors, for example through the use of a standard XML document (like a CCD) that contains data points a third party could use to determine whether or not the practice meets Meaningful Use.
- Ensuring PHRs contain the most amount of useful data possible by ensuring the “tethered PHR model” does not become a dead-end for patient data.
- Ensuring that the ONC EHR certifying process aligns with what providers are asked to demonstrate for Meaningful Use. For instance, it will be hard for providers to select any three non-core clinical quality measures for reporting, if EMR vendors are not required (per temporary ARRA certification) to have coded all 38 Menu Set clinical quality measures.
- Ensuring that all providers have access to a free, easy and secure way to exchange information across all health care settings. We applaud the efforts of NHIN Direct and look forward to more stringent Meaningful Use measures that help entrench these new workflows once providers universally have access to health information exchange.

On behalf of our wonderful team, without whom our project would not be the success it is, I thank you for your time and consideration, and for inviting me to speak with you today to share our experiences from the field. I would be happy to address any additional questions or concerns you may have.