

**Current Health IT Support of Care Coordination
Testimony of Peter Basch, MD – before the Meaningful Use Workgroup of the Health IT Policy
Committee, August 5, 2010**

Good morning, and thank you for this opportunity to briefly discuss care coordination and its enablement (and/or lack thereof) in existing health IT and EHR systems. By way of background, I am a practicing general internist here in Washington, DC, and an early adopter and user of all things health IT. My practice (7 primary care doctors) is a current participant in a 2-year regional Patient-Centered Medical Home pilot.

My work with the Center for American Progress and with the Brookings Institution is centered on the following:

1. Identifying and clarifying gaps / weaknesses in existing health IT and EHRs in support of health policy objectives;
2. Identifying where policy needs to be developed / refined to support the development and maturation of health IT, its adoption by providers and other stakeholders, and its optimal use towards making care better, safer, and more value-laden; and
3. Working towards realistic and incremental solutions that can be iteratively adopted and improved – such that health IT and EHRs are not relegated to a theoretical future state, but rather can be used today to improve care.

You have tasked this panel with addressing the following two questions:

1. What are the key care coordination needs that are being, or could be addressed using health information technology (HIT) today? – and...
2. How has the electronic health record (EHR) supported, or not supported, your medical home to date, and what are potential implications for future meaningful use requirements (e.g., stage 2 or 3)?

I will start with question #2. My small practice here in Washington, DC is part of a regional patient-centered medical home pilot which is being conducted by a large private payer. Our practice has been using a commercial EHR for the past 13 years, and has customized content and clinical decision support, and has purchased additional bolt-on reporting capabilities for this project. At this point, we have made great strides in all 9 of the NCOA standards for the PCMH, are showing measurable and in some cases, dramatic improvements in quality metrics, and have met the NCOA requirements for a level 3 medical home.

I could say then that our EHR implementation with our added content, clinical decision support, and reporting tools has fully supported our medical home pilot. As I look forward to the Stage 1 care coordination requirements of Meaningful Use (capability to exchange key clinical information with other providers and medication reconciliation where appropriate), I am equally satisfied with my EHR implementation. And as I look forward to the probable specific objectives for Stage 2 Meaningful Use within the dimension of care coordination (receiving and acting upon prescription fill data, producing care summaries for care transitions, and performing medication reconciliation), I feel similarly optimistic. When it comes to Stage 3 care coordination objectives and metrics, I am less certain, as these metrics are essentially unknown.

However, as I attempt to answer question #1 (what are the key care coordination needs that are being or could be addressed using health IT), I find myself struggling, as in my view, neither the HITECH Act nor

the draft nor final rule for Meaningful Use present a meaningful definition of care coordination. Without that definition, I could answer similarly as above; using the existing objectives and metrics to divine a definition of care coordination, I would say we are addressing that non-definition of care coordination for Stage 1, and draft non-definition for Stage 2 very nicely. However, that presumed definition is not adequate, based on my understanding of how care coordination should be defined or operationalized, and answering your question of what care coordination needs could be addressed is very different when an actual definition of care coordination is on the table. And until we agree on a meaningful definition of care coordination, I believe we all will fail in our efforts to support care coordination with health IT.

The use of health IT to support care coordination is prominently referenced in the HITECH Act and in the final rule for Stage 1 Meaningful Use. However, its reference as one of the three key areas for meeting Meaningful Use is only tangential (“...demonstrates to the satisfaction of the Secretary that certified EHR technology is connected in a manner that provides for the electronic exchange of health information to improve the quality of health care *such as promoting care coordination...*”). Furthermore, the construct of this tangential reference is entirely within the sphere of health information exchange. However, care coordination is far more than health information exchange.

In June of 2007, The Agency for Healthcare Research and Quality defined care coordination as, “...the deliberate organization of patient care activities between two or more participants...to facilitate the appropriate delivery of health care services. Organizing care involves the marshalling of personnel and other resources needed to carry out all required patient care activities.”

Also in 2007, McAllister et al. defined care coordination as an “...outcomes focused process designed to facilitate the provision of comprehensive health promotion and chronic care; with a locus on ongoing proactive planned care activities...”

Approximately a decade ago, the Institute of Medicine identified the lack of effective care coordination as one of the key deficiencies in our health care system. The absence of effective care coordination is closely linked to poor communication between providers (in multi-provider care and in care transitions); unwarranted redundancy; and to patients and care givers feeling lost and alone in attempting to navigate an increasing complex healthcare delivery landscape.

As someone who has practiced primary care for almost 30 years (about ½ on paper, and ½ with an EHR), I am convinced that these statement of problem and solution – are on target. Care coordination is more than the availability or movement of data. It is an ongoing process of retrieving and/or seeking information; consuming and translating that information; validating that information as it pertains to the current health and chronic care plans of the patient; reconciling differences between conflicting recommendations of different providers; and effectively communicating the totality of that information to the patient.

The existing Stage 1 final rule objectives and the currently described Stage 2 and Stage 3 Meaningful Use objectives for care coordination restrict themselves to the enablement of health information availability and mobility. These objectives and the Stage 1 Meaningful Use metrics are silent as to the process of care coordination as defined by AHRQ and McAllister, and as I operationally define it above.

I will presume that the Meaningful Use Workgroup and the Health IT Policy Committee are seeking testimony not for the current state of health IT to enable data transfer, but rather for what the IOM,

AHRQ and the American public considers care coordination, and of course for what Dr. Fernandopulle found lacking in his EHR implementation, and for what the Center for the Study of Health System Change found lacking in their recent published survey.

As you are all aware, even the best provider facing EHRs are constructed to support the existing paradigm of care and care documentation – which is almost entirely visit and encounter based, and which ends in a legal document typically produced and attested to by a sole provider.

What follows is what I believe would transform the EHR into a tool that would support actual care coordination:

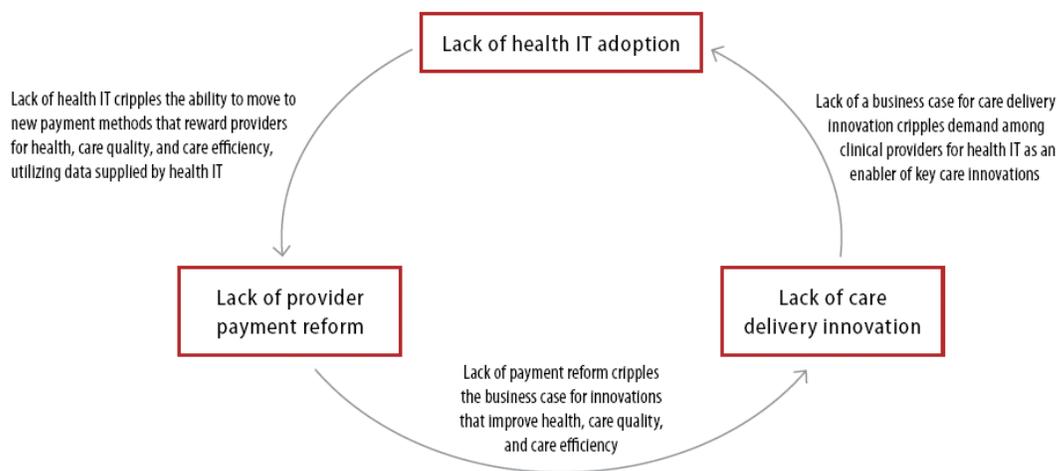
1. The ability to easily attribute multiple providers to a patient, further creating attribution by condition.
2. The ability to use that attribution to create virtual care teams.
3. The ability to operationalize these virtual care teams (which of course includes context sensitive secure communications), whenever:
 - a. New pertinent results are available;
 - b. A change in therapy is necessary;
 - c. A new symptom / side effect develops; and
 - d. The patient / family / care-giver have questions / concerns.
4. The ability to anticipate when an expected result / ongoing consultation should arrive (or should arrive and does not).
5. The ability to create, share, and modify care plans between providers and patient.

I would like to point out, as Todd Park (current CTO of HHS) and I wrote over a year ago in a publication for the Center for American Progress – the reason that such capabilities don't exist now in EHRs is less due to technologic limitations than to the lack of a business driver for their development. As my EHR vendor responded when I asked for these enhancements about 5 years ago, "Well that will give us exactly one satisfied customer; but would probably drive away many existing and new customers – who are already complaining about EHR complexity."

This vicious cycle that Park and I described and is diagrammed below:

The Vicious Cycle

The interconnected failure of health IT adoption, provider payment reform, and care delivery improvement in our current health care system



Correcting this vicious cycle in real care coordination software development, purchase, and use will unfortunately not occur due to the intervention of Meaningful Use incentives or penalties, as at least as currently described, the metrics for Meaningful Use do not address real care coordination.

Sustainable business drivers for these EHR enhancements will come from such payment reforms as the Patient Centered Medical Home and many variants of Accountable Care Organizations. Stated another way – once there is a business case for effective care coordination, tools will be developed, refined, purchased and used.

I understand that changing the way that healthcare is paid for is difficult, and cannot be done overnight. There is a danger however in not striving for that goal, and instead relying on the existing non-definition of care coordination, and its corresponding data mobility metrics. If that is where care coordination is left, EHRs and health IT will continue to disappoint providers and patients, and care coordination will never be valued appropriately. This will further disappoint providers who are potential care coordinators (further dooming the chances of a primary care revival), and more importantly, let down patients and their families, who deserve far better.

The need to enable real care coordination is clear and compelling; the health information technology to enable care coordination is here or within reach. Providers will find that these tools embedded in their EHRs or EHR technology will make the process of care coordination far easier than it would be to do with paper records. However, until our health care system creates a compelling and sustainable business case for care coordination, our efforts in that area within health IT will remain unfocused and unsatisfactory.

It is hoped that this workgroup, along with the HIT Policy Committee and CMS, could begin the process of course correction by constructing objectives and metrics for Stage 2 and Stage 3 of Meaningful Use that address care coordination as more than data mobility and availability.

Thank you and I am available for your questions.