

## Meaningful Use Testimony 10.28.09

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### Introduction

For the past 27 years, I have practiced as a Family Nurse Practitioner, providing care to people from prenatal to elderly, mostly in federally-funded inner-city Community Health Centers in Philadelphia and New York. I have taught for more than 15 years at the graduate level. After completing a PhD in Nursing from the University of Pennsylvania in 1993, from 1993-2002, I directed the Adult NP and FNP programs there. From 2002 through 2005, at Columbia University, I co-directed with Suzanne Bakken a HRSA-funded project to develop and implement a hand-held computer documentation system for NP students. I also taught informatics and family nurse practice at Columbia. In 2006-07, I taught nursing research to doctoral students and health assessment to undergraduates at Seton Hall University.

The application of informatics in primary health care is my research interest, including electronic documentation for providers and consumers, the use of standardized terminology, and decision support related to quality of care. I have published and presented a great deal regarding primary care and also informatics. I am an active member of the American Medical Informatics Association's Primary Care and Nursing Informatics Work Groups and a long-time member of the American Nurses Association.

I came of age in the 1960's—during the previous US health care reform efforts when Medicare, Medicaid, and NPs began. I was involved in the women's health movement—remember "Our Bodies, Ourselves"?—and I appreciate the power of active and educated patients.

As you may know, Nurse Practitioners (NP) and Certified Nurse-Midwives (CNM) are directly paid by Medicaid, Medicare, and many private insurers for primary care encounters and we are essential providers in this time of limited access to primary health care. Multiple research studies document the quality of care of Advanced Practice Nurses to be equivalent or better than physician care at lower cost

<http://www.aanp.org/AANPCMS2/Publications/PositionStatementsPapers/>. In particular, Advanced Practice Nurses have been shown to increase patient satisfaction, spend more time with each patient, and provide more patient education than physicians. Collaborative NP/physician teams have been shown to lower hospital length of stay and costs.

Due to our efficient educational preparation, as compared to primary care physicians, the numbers of NPs and CNMs are growing rapidly. According to the "National Sample Survey of Registered Nurses March 2004:Preliminary Findings" (Health Resources Services Administration, 2005), in March 2004,

there were an estimated 141,209 nurse practitioners with credentials as NPs in the United States, an estimated increase of 38,560 from 2000. The GAO reported in 2008 (GAO-08-472T) that there were over 82,000 NPs in primary care. It is safe to say that now there are upwards of 100,000 NPs to join with the estimated 260,000 physicians in the US that provide primary care. And, as of April 2009, there are 11,546 CNMs/CMs in the US, serving diverse populations. [http://www.acnm.org/media\\_kit.cfm](http://www.acnm.org/media_kit.cfm). The average annual NP salary in 2009 is lower than that for primary care physicians, ranging from \$85,000 to \$100,000 (<http://www.eri.com/index.cfm?fuseaction=research.Nurse-Practitioner-salary-survey-data-details&PositionId=8022&CityId=300>). The average CNM salary ranges from \$82,000 to \$122,000 <http://www.salaryexpert.com/index.cfm?fuseaction=Browse.Registered-Nurse-Midwife-salary-data-details&PositionId=105192>.

After the initiation of Nurse Practitioners in Pediatric, Family, Adult, and Women's Primary Care, Advanced Practice Nurses have gone on to develop many specialties, and they may work in acute care settings. At the present time, an estimated 85% of NPs have been educated in primary care programs. The GAO in 2008 stated that they defined primary care nurse practitioners as "those practicing in adult, family, and pediatric medicine." The GAO further stated that "other types of health professionals, such as registered nurses, can provide primary care services in a variety of settings." (GAO-08-472T) It is safe to say that Family, Adult, Pediatric, and Women's Health NPs working in a community-based primary care setting, (like a community health center, hospital outpatient department, or private practice), are providing primary care. In addition, some NPs who have been through primary care educational programs may provide limited primary care while working inside a specialty office. For example, I have heard of a pediatric NP, working with a physician allergist, who provides primary care. This would be acceptable under many state licensing laws. In those much less common cases, primary care could be determined by the % of diagnoses related to routine health maintenance examinations and a selection of common primary care problems.

Recognizing the contribution of Advanced Practice Nurses to primary health care, the American College of Physicians has gone on record to recommend that quality measures and incentives for NPs be equivalent to those of physicians and that NPs lead "Patient Centered Medical Homes". This fits with the principle of equal pay for equal work and contributes to the preservation of antitrust remedies, by ensuring that no individual group of health care professionals receives unfair advantage under the law.

1. How will the proposed 2011 and 2013 meaningful-use objectives and measures help your specific area (pediatrics, psychiatrist, nurse practitioner dentists, etc.) demonstrate that they are improving care?

- 1.1. Quality Improvement is meant to reduce medical errors and needless morbidity and mortality

[http://patientsafetyed.duhs.duke.edu/module\\_a/introduction/introduction.html](http://patientsafetyed.duhs.duke.edu/module_a/introduction/introduction.html). NPs, CNMs, and physicians should use the same quality measures for primary health care. The proposed meaningful-use measures are appropriate and as should future measures from NQF. Improvements would be shown by periodic measures getting better and going past national norms. It is imperative that Advanced Practice Nurses' work be identified as such, even though billing for encounters may be done using a physician's name. Since the major purposes of EHRs and PHRs are to support patient choice and self care, as well as to address cost and quality issues, health disparities, and chronic care management, it is important to understand the differences in provider care management practices and effective practice patterns within disciplines. See [www.acponline.org/advocacy/where\\_we\\_stand/policy/np\\_pc.pdf](http://www.acponline.org/advocacy/where_we_stand/policy/np_pc.pdf). Please adjust the physician-specific language in the meaningful use document to include Advanced Practice Nurses.

- 1.2. Registered Nurses (RN) should be added as eligible providers for EHR use in community/primary care, including RNs working in areas such as home care, hospice, care coordination, nurse-family partnership (<http://www.nursefamilypartnership.org/index.cfm?fuseaction=home>), school health, and public health. I agree with the American Academy of Nursing's statement that RNs gather much of the data that are essential for effective primary care and continuity of care across settings. See <http://www.aannet.org/i4a/headlines/headlinedetails.cfm?id=219>.

Homecare agencies provide care to the most complex patients, with multiple chronic conditions, who require a disproportionate share of healthcare expenditures. These patients would consume an even greater share of healthcare expenditures if homecare were not available to manage their condition, which prevents expensive use of the emergency department and re-hospitalization.

To achieve the goals of improving outcomes and reducing cost, meaningful use of EHR's by hospitals and physicians needs to include the exchange of the patient's clinical information with homecare providers – in both directions – for greater collaboration across the continuum of care. The increased use of EHR's by homecare providers supports this exchange and collaboration.

- 1.3. To quicken EHR adoption and multidisciplinary use, other professionals with a sufficient volume of their work in primary and community health care, such as dietitians, social workers, physical therapists, psychologists—many of whom are directly paid by Medicaid and Medicare--should be included also as eligible providers with measures appropriate to their work.
2. What are the special considerations when applying meaningful use measures to your specific area or to underserved populations?

2.1. The goal of populating PHRs with real time EHR data is the top priority for NPs and other nurses. 2013 is none too soon for this because PHRs have the potential to greatly facilitate communication essential for continuity of care and to solve much of the struggle for interoperability. The existing, carefully developed, Continuity of Care Document standard should be available in addition to encounter summaries [http://www.hitsp.org/ConstructSet\\_Details.aspx?&PrefixAlpha=4&PrefixNumeric=32](http://www.hitsp.org/ConstructSet_Details.aspx?&PrefixAlpha=4&PrefixNumeric=32) . Patients should be able to download and transmit data in a format acceptable to document exams for school and work, as well as for other health care providers.

2.2. PHR data must be in the patients' language and should be linked to educational materials and information about relevant community resources. PHRs must accept patient-entered data, including home monitoring data. For example, prescribed medications should be linked to the related diagnoses, information about the drug actions and side effects, related lab or monitoring procedures, cost, and where available for purchase. In addition, a flow sheet or diary of medication-taking and any related problems should be available to the patient.

A very recent development by the National Library of Medicine's staff is an open-source module that automates a hyperlink from common ICD9-coded diagnoses to the relevant introductory page in MedlinePlus. This module could readily insert into PHRs with a standard CCD problem list to direct patients to a wealth of timely, accurate, non-commercial information that is available in up to 40 languages.

2.3. Access to PHRs and secure messaging should note how data are transmitted (internet, mobile phone data, texting) and should be compared with actual use of the tools. Patients must be assured of access to shared records after they cut ties with the professionals who provide the data.

3. What other measures would you propose be considered to assess the meaningful use of EHRs by your specialty, and how would they align with the care goals and objectives the Policy Committee has recommended?

3.1. Data related to optimal patient health and function include... self-assessed "health status, health assets and deficits, information on family caregivers, and [interdisciplinary] interventions provided to address any of the 14 physical and physiological functions that the patient is unable to perform independently or without assistance from devices" (<http://www.aannet.org/i4a/headlines/headlinedetails.cfm?id=219>). These data items are not typically captured in current primary care EHRs but are included in the mandated home care Outcome and Assessment Information Set (OASIS) and are collected, at specific time frames, encoded and electronically transmitted to each state's agency. (See the

example attached.) A recent survey found that over 65% of home care agencies use electronic record systems [http://fazzi.com/research/state\\_of\\_industry\\_study.html](http://fazzi.com/research/state_of_industry_study.html). Many RNs providing home care already document OASIS electronically and could provide selected quality measures. Home care provides a model of secure data transmission to a central state agency that Medicaid providers might use.

- 3.2. Recommended additional measures related to patient chronic disease self-management include: a) patient self-management goals and related provider support; b) percent of chronic disease encounters with documented med reconciliation and med-taking assessment, and c) percent of patients at each follow up visit with a documented goal related to chronic disease.
- 3.3. Measures to track referrals related to social realities that influence health (income level, employment, transportation, education, housing, safety in the home, etc.) should be included in EHR and PHR documentation, as well as dates they were followed up for the underserved, uninsured, and Medicaid patients that have fewer resources than many of us.
- 3.4. Access to information about community resources in the PHR is essential for informed decision-making and active self care.
- 3.5. A suggested efficiency measure is percent of normal blood chemistry tests and normal PSA tests repeated in a given patient group within 6 months.
4. What are other EHR adoption barriers unrelated to the definition of meaningful use, that affect providers like you? What solutions would you recommend to address those issues? What would your role as a provider be in this solution?
  - 4.1. Lack of professional education regarding informatics is the major barrier to EHR adoption. This includes basic preparatory education in the discipline as well as continuing education for working professionals and education specific to the EHR in use. Because providers have traditionally been taught to focus on individual patients, education needs to emphasize the value and effective use of EHRs for aggregate patient groups. My role as a provider is to teach and encourage colleagues and patients to jump into the information age by gaining skills and using new tools.
    - 4.1.1. AMIA, the American Medical Informatics Association, holds several annual conferences and specific internal working groups to highlight recent developments and research in primary care and nursing informatics. See <http://www.amia.org>.

- 4.1.2. AMIA also has begun the “10 X 10” program to encourage continuing professional education in informatics through established University programs (<http://www.amia.org/10x10>). Currently, I believe the courses offered are survey courses. More applied courses in implementing EHRs and PHRs could be encouraged. I recommend that AMIA organize a training course for regional extension centers to promote consistency and best practices. Possibly the Primary Care Information Project in NYC could initiate the curriculum and content in cooperation with an academic program.
- 4.1.3. The nursing TIGER consortium (Technology Informatics Guiding Educational Reform) <http://www.tigersummit.com/> is currently working through many organizations to “interweave enabling technologies transparently into nursing practice and education to allow informatics tools, principles, theories and practices to be used by nurses to make healthcare safer, effective, efficient, patient-centered, timely and equitable.” See the attached summary report that defines three essential competency levels (basic, information literacy, information management) and suggests learning resources for nurses and other healthcare professionals.
- 4.1.4. Specific training is needed for the EHR in use on site. A good example is at the Community Health Network in NYC, with over 100 primary care givers, which, like many CHCs, has the infrastructure to support initial and ongoing training. Kameron Wells described to me his plan for live webinars for small groups of providers to learn how to use the decision support system in their EHR and to generate registry “report cards” for themselves. He plans to continue with update webinars every 2 months or so.
- 4.2. Computer skills education for consumers will speed the effective use of PHRs and other electronic tools. People, especially those over age 50 and those with limited language literacy, would benefit from the whole or even parts of the European Computer Driving License course. Consumer organizations, Community Health Centers, and health systems should be encouraged to sponsor a comparable course in accessible settings like libraries and senior centers. TIGER members have identified 4 modules from the course that contribute to basic competency: Module 1: Concepts of Information and Communication Technology; Module 2: Using the Computer and Managing Files; Module 3, section 3.1: Word Processing; and Module 7: Web Browsing and Communication. See <http://ecdl.com>.
- 4.3. I recommend that, over time, EHR and PHR data elements and measures be brought in line with national standard surveys such as the National Ambulatory Medical Care Survey (NAMCS), National Health and Nutrition E Survey (NHANES), and the Uniform Data System (UDS) required for Community Health Centers. This will enable efficient sampling of large populations and facilitate a variety of public health

reports.

- 4.4. Patient privacy must be protected by new laws that prohibit re-identification of de-identified data. I believe that when health insurance coverage is guaranteed regardless of pre-existing conditions, privacy will be a much less anxious issue.

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**ATTACHMENTS:**

1. Mock OASIS data from a home care RN's 485 plan of care
2. TIGER nurse informatics competencies and resources