

HIT Policy Committee

Hearing on Meaningful Use Measures Related to Specialists, Smaller Practices and Hospitals, and Providers of Underserved Populations

Underserved and Medicaid Providers Panel
Pediatrician - Alan Zuckerman, Georgetown University
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Dr Blumenthal, Dr Tang, and members of the Committee, Thank you for giving me this opportunity to share with you my concerns, and those of my pediatric colleagues, about the need to address child health issues for meaningful use of certified EHR. I will try to focus on meaningful use measures proposed by this committee rather than the details of certification criteria, standards, and quality measures that are taking shape in the HIT Standards Committee

My name is Alan Zuckerman and I am a general pediatrician practicing at Georgetown University Hospital located only two and a half miles from this hearing. I am a Medicaid provider in three states, District Columbia, Maryland, and Virginia and my university based practice sees about 25% Medicaid patients. Note that under ARRA for purposes of Health Information Technology DC is a state! We implemented a certified EHR in our practice during the past year and this is our eighth month entering all general pediatrics encounters in the EHR. I served as the Medicaid physician on the Health Information and Data Exchange Taskforce of the State Alliance for e-Health that examined Medicaid and Health Information Exchange. I am a co-chair of the Certification Commission for Health Information Technology (CCHIT) Interoperability Workgroup and an elected member of the Executive Committee of the American Academy of Pediatrics (AAP) Council on Clinical Information Technology.

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?

The primary objectives and measures for 2011 and 2013 that will demonstrate improvements in child health deal with immunizations. Immunization recommendations and available immunization products are changing frequently and must also include disaster preparedness and response to public health threats. Aggregation of lifetime data is essential and the decision rules based on the recommendations of the Advisory Committee on Immunization Practices (ACIP) are complex. Up to date immunization assessment involves more than just counting doses of vaccines or following a single routine schedule because some vaccines are age specific, some doses given at the wrong time do not count, and catch-up rules (that must be used when children are behind, new vaccines are introduced, or vaccine shortages resolved) are complex and specific.

I think that many of my colleagues fail to see the potential and power of the framework of goals and objectives that your committee has developed because they have not been applied specifically to children, but their potential impact is substantial when proper settings for their application to child health are considered.

Consider the all important and very conspicuous usual first transfer of care when over four million newborns leave the hospital to begin outpatient care as the next generation of Americans. Unlike many other transfers of care, we have a clear denominator because all newborns seen in the office less than 30 days of age will be part of this group. Incorporating lab

results into the EHR, sharing information with patients electronically or giving them access to their health information electronically, and providing patient-specific education materials in their primary language, and sending patient reminders for preventive care (such as the need to refer for repeat newborn hearing testing) can enhance newborn care and timely information transfer between the hospital, ambulatory practices, and public health.

In my practice, I enjoy the important benefits of sharing a single chart with my patient's specialists who are based at Georgetown and I can read incoming faxes and letters from other hospitals in the EHR. My experience of the past year with several patients who have special care needs has dramatically shown me the value of health information exchange in coordinating care when medication doses change and lab tests are ordered by several different providers for the same patient. This is purely an accident of our multi-specialty sharing of an EHR and all children need to get these benefits by moving data between the EHR of all of a child's health care providers.

An important role of the meaningful use objectives and measures is to provide guideposts to vendors and to my pediatric colleagues about setting priorities for functions in the EHR which have an impact on the care that patients receive and not just the quality and quantity of our documentation. We cannot do everything an EHR is capable of doing and it is helpful to have specific targets of what to do first such as making sure immunizations are up to date. This is actually a task that few vendors do well and the attention it is receiving is helping to advance this form of clinical decision support.

What are the special considerations when applying meaningful use measures to your specific area or to underserved populations?

Children are not just small adults and meaningful use objectives will require adjustments and measures that focus on different conditions for effective use in children. When pediatricians look at your objectives and measures they quickly point out the lack of head circumference in the vital signs for a patient summary and the lack of weight based or liquid dosing for electronic prescribing which are the canary in the coal mine for pediatric enabled EHR. Attention to growth and development is another vital component of child health that uses data over time.

Chronic disease in children is very different from adults. Two very common conditions, Attention Deficit Disorder and Asthma affect approximately 10 percent of children and require long term medications and self management skills. The childhood versions of common adult chronic diseases such as hypertension, diabetes, and hypercholesterolemia are relatively uncommon, more severe, and managed differently in children than adults. The real goal is preventive services to reduce adult risk factors and meaningful use of EHR in children should focus on tracking these services rather than managing the early onset of adult conditions. Electronic prescribing in children is about Ritalin and Concerta over time and not about short term pain medications or addiction risk of low back pain. We need electronic prescribing of controlled substances for children to keep them on all of the medications they require. We are still waiting for final rules from the Drug Enforcement Agency.

Pediatrics as a special is a combination of primary care for children by general pediatricians, and also specialty care for children by a variety of sub-specialists. An adult primary care measure such as Hemoglobin A1C control maps to a specialist measure for children. Blood pressure control or cholesterol control in children focuses on detection and approaches to management and expected outcomes will be different from adults

Consider Body Mass Index BMI in children over age 2, like other growth parameters, the norms must be treated and percentiles dependent on age. While detection is vital, intervention is difficult and may be starting too late to be effective in the short term during times of growth and development. The key to pediatrics is prevention and counseling and anticipatory guidance at younger ages for all children that may be more important than expecting changes from tracking the obese. Tracking is critical, but change may not be controllable by the provider.

Weight based electronic prescribing is critical in childhood along with safety checks to prevent exceeding usual adult doses when relying on weight based calculations alone.

As a member of AAP I fully support their recent policy statements on Pediatric Requirements for EHR, Using Personal Health Records to Improve the Quality of Health Care for Children, and Electronic Prescribing Systems in Pediatrics that may be helpful to the committee and elaborate on meaningful use considerations for pediatrics.

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?

Recording Newborn screening results in the EHR using electronic laboratory reports where available, and documenting patient-specific information distribution where appropriate. These results should be checked by two weeks of age and any repeat confirmatory testing and immediate treatment initiated when required.

Follow-up of newborn hearing screening that was not passed on the most recent test including sending results to public health.

Weight based prescribing and dose calculations for liquid medications which can be measured as a percentage of prescriptions or entries in a medication list that include weight at the time of prescribing and a computed dose per kg body weight per day (where appropriate for the medication) and a check against exceeding adult dosing.

Pediatric growth tracking including height, weight, head circumference (under age 2), and body mass index (over age 2), using standardized growth charts and percentile norms.

Pediatric blood pressure norm checking based on age and height using percentile norms

Documentation of developmental assessment and preventive care counseling

Sharing immunization and growth records with parents in a human readable form

Viewing and storing family health history collected by the patient in portable electronic format.

Adolescent patients have special privacy considerations regarding access to a personal health record or confidentiality of selected entries in their electronic medical record subject to restriction by state law. Child specific additions to privacy and security for children in foster care, with special custody arrangement, and for adolescents are a potential extension of meaningful use objectives and their implementation and use can be measured.

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?

Without a doubt, the most overwhelming barrier to meaningful use is the concern over whether pediatric practices will be eligible to receive funds based on their percentage of Medicaid and if they will be able to sustain those percentages after they have decided to participate in the program.

When I served on the State Alliance for e-Health Taskforce, the Medicaid directors, state officials, and the Governors who received our recommendations, realized quickly that it made sense to talk about providing HIT to all children in a state because of the constant and frequent changes in Medicaid status.

If you do not try to include all children, even when they are not on the Medicaid rolls, the data you need to care for them when they are on Medicaid will not be available in electronic form. We have learned that lesson from registries and other data systems that drop patients when they lose their Medicaid

When we issued our first report to the nation titled *Accelerating Progress: Using Health Information Technology and Electronic Health Information Exchange to Improve Care* in October 2008 [available at <http://www.nga.org/center/ehealth>] it included a recommendation to "Make a patient-centered, interoperable, and portable EHR available for every child by 2014. This was a visionary insight of the State Alliance for e-Health that recognized that all children, not just those covered by Medicaid, must be included because of frequent changes in coverage and parental employment as well as movement from state to state during childhood. Other recommendations were specific to the role of Medicaid as an insurance provider that could provide certain services, such as a personal health record, to their eligible beneficiaries. We see some of the implementation of these recommendations in the Children's Health Insurance Program Reauthorization Act (CHIP-RA).

There are many differences between Medicare and Medicaid, but none is more important to me than the fact that once you turn age 65 you will almost never lose your eligibility for Medicare and nearly all patients your age will be covered regardless of where they live. Medicaid, on the other hand, is a virtual revolving door with frequent gaps in coverage and considerable regional and state to state variation in coverage. I see in my own practice how families move in and out of Medicaid. Pediatricians simply do not have the ability to control the level of Medicaid patients in their practice because it is governed by so many factors and coverage is constantly shifting. The fear of not qualifying for incentives or losing those incentives in the middle of a budgeted implementation is discouraging pediatricians from lining up to begin meaningful use under ARRA. There are also strong concerns about state to state variation in the meaningful use measures that will make purchasing an EHR from a national vendor challenging and certification of EHR much more difficult than a single child health add-on certification.

I know that we must obey the law requires at least 20% Medicaid patients, but laws that do not work can be changed. Perhaps the regulations might take into account adjustments for the pool of potential Medicaid patients in the community and the fact that other patients in the practice will move in and out of Medicaid at some time during their childhood. What is important is to promote equity by not including practices that exclude Medicaid patients and including those who accept those who accept Medicaid patients that select them for care. Member surveys at the American Academy of Pediatrics suggest that over half of solo, small, and medium practice

cannot make the 20% cutoff and a third of practices could not even reach the 10% level. Even my practice, over the years we have moved above and below the 20% and not exceeded 30% despite our open and one class approach to quality care.

Consider the case of children in foster care, an important segment of the Medicaid population who utilize services at four times the rate of other Medicaid patients in part due to gaps in previous coverage. On any given day we estimate that 500,000 children are in foster care, but by the end of a single year over 800,000 children will have spent some time in foster care and over 18 or 21 years of childhood, the proportion is much larger. Also, as among the rest of Medicaid recipients, the rate varies considerably by state and region.

We have a special moral obligation to provide health information technology to all children, particularly if we believe that it can improve their care, because they cannot do it for themselves the way that adults can by using personal health records or selecting a technology enabled provider. Children are completely dependent on their parents, physicians, and society, not just for their nutritional needs but also for their current and future information needs. AAP understands this, and relatively unique among other professional societies advocates a dual mission to promote the health of children as well as the needs of their pediatrician members. It says so right here on the AAP Tie I am wearing that reads "Dedicated to the Health of All Children".

The care of children is heavily dependent on information gathered over the entire period of childhood. This committee should be aware that the NCAA will require that all college athletes are screened for Sickle Cell Trait. The purpose is not to exclude 8% of the African American population, and others who also carry the trait, from participation in sports, but instead to protect those athletes from the avoidable tragedies that have been associated with certain rigorous hot weather conditioning programs. Every state screens all newborns for this trait at birth, but meaningful use of available information technology is required to get that information into the EHR and to preserve it for sharing with the patient when they are older as well as to make it available should they enter college athletics thus avoiding costly and inefficient duplicate testing. Like many components of newborn screening, there is value to those who screen normal to know that information through positive confirmation and electronic data transfer.

It is impossible to be held accountable for many meaningful use measures in childhood without access to past data that often resides with previous providers or in state health departments.

We must taken into consideration the special issues regarding bring health information technology to safety net providers. Although approximately 40% of children in the US on are receiving Medicaid each year (and perhaps the majority of children will be on Medicaid at some point during their entire childhood) only about half of them are seen in small to medium sized private practices. The rest are at large academic health centers, like my practice, or at community health centers. EHR adoption at Community Health Centers according to the National Ambulatory Medical Care Survey is ahead of the small to medium offices at 25% compared to 15%. Cost dominates decisions in both settings, but health centers at about 35% Medicaid will almost always be eligible for maximal incentives. They do see a lower return on investment in EHR due to their different revenue mix, fixed compensations, and large proportion of uncompensated care.

Health Centers in rural and inner city areas face challenges in obtaining Internet access and even bigger challenges in finding and employing qualified information technology support. The fragmentation of care among health center patients may make it difficult to document

information from care provided through a mix of providers over time so that they might be meeting meaningful use measures but be unable to document it based on the data in their own systems. They are at a disadvantage in gaining access to Health Information Exchange except in areas such as New York City where the problems of cost of system installation, availability of technical support staff, and available health information exchange to support quality measures have been addressed as a package for Medicaid providers.

In both the private practice and the health center settings, I hear real concerns about how the data from meaningful use measures will be made public and compared between practices. These dedicated providers of care to the disadvantaged populations anticipate not looking good on many proposed measures, in part due to discontinuities in past care for the patients. Their ambition is to use the EHR to improve those measures. They also express fear about new measures and open access to their data resulting from signing up for incentives. Some reassurance to these providers about a focus on practice improvement and non disclosure of practice identity of ARRA funds recipients may help encourage more practices and health centers to consider using the funds.

Other challenges and barriers that span health care settings for the disadvantaged include engaging and informing patients about the new roles they can play in meaningful use as well as to prepare them for the disruptions that are an inevitable part of new EHR implementations. Consumer participation and empowerment is essential, but sometimes hard to achieve in disadvantaged settings. Training and change management are also critical to engage staff in their new roles and make the transition to EHR a team sport where everyone who participates benefits from what may appear to be a painful process.

Thank you for this opportunity to look at the special health information technology needs of children and the barriers to bringing meaningful use of EHR to a large number of providers. Please remember that children are a quarter of our population, but all of our future even if they cannot vote today. Please see that children are included in meaningful use measures and that ARRA incentives for EHR are offered to the widest possible proportion of practitioners who care for children. Kevin Johnson, Joseph Schneider, Eugenia Marcus, and other colleagues would be very willing to join me in working with you on mapping of your objectives and measures for children and any other tasks that would assist your work.