

**Testimony of Francis X. Campion, MD, FACP, Outcome Sciences, Inc.
MU Workgroup Hearing
May 13, 2011
8:30 a.m. to 2:45 p.m./Eastern Time
Washington Hilton Hotel, 1919 Connecticut Ave, NW
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Thank you for the opportunity to present today. My name is Francis Campion. I am a medical director with Outcome Sciences, a company focused on patient registries. My comments are based on the experience of Outcome Sciences, of more than 13 years working with over 30 medical and surgical specialties through national programs with their professional societies and patient organizations.

I would like to describe three national specialty programs. Our professional societies represent a key and trusted constituency that bring expertise, infrastructure, content, professionalism and a track record to using data for population management and performance improvement. My comments on EHRs focus on providing standardized methods for interoperability that can accelerate the reach of these clinical registry programs. We specifically recommend rapid adoption of the HITSP TP-50 and related interoperability standards for EHRs. This will enable the current Continuity of Care Document (CCD) to be used for data interchange.

The American Heart Association Get With the Guidelines program began over 10 years ago, and now includes three different registries, stroke, heart failure and cardiopulmonary resuscitation. Over 2,000 hospitals participate and have accrued well over 2 million cases. In addition, the AHA and the American College of Cardiology share the ACTION-GWTG Registry focused on acute myocardial infarction. Hospitals and physicians compare their performance to national benchmarks and seek improvements in care. In multiple publications, these programs have demonstrated sustained improvement in a broad range of quality measures. Examples include significantly lowering the time to treatment with thrombolytic therapy in acute stroke, lowering the 30 day readmission for heart failure and improving airway management for resuscitation.

The American Society of Clinical Oncology QOPI (Quality Oncology Practice Improvement) registry includes modules on lymphoma, and breast, colon, and lung cancers. Over 700 oncology practices representing 25% of all oncology practice sites in the U.S. participate. The program includes more than 100 clinical measures in pain management, chemotherapy administration, end of life care and other areas. ASCO has created the oncology practice certification program which is now recognized by the Blue Cross Blue Shield Association, Anthem and other insurers for their own quality incentive programs.

In 2002 the American Society of Plastic Surgery began its national registry, Tracking Operations and Outcomes in Plastic Surgery, also referred to as "TOPS". Hundreds of plastic surgeons use TOPS to improve practice and complete CME and Maintenance of Certification requirements.

These national programs have all been successful to date but hold even greater promise for widespread adoption across their specialties. Two key issues that can be addressed by this Committee are provider incentives and EHR data interoperability. These programs would flower and meet their true potential if they were a) designated as meeting federal and state requirements for performance measurement, in particular meaningful use, and b) leveraged existing electronic data from EHRs using interoperability standards.

I therefore would like to turn my attention specifically to the second issue of leveraging existing electronic data. Open data standards, have been developed by IHE, CDISC and others, and recognized by the HIT Committee. Broad adoption of these standards by EHRs, would advance many of the registry programs into the mainstream of daily practice. Let me give you an example from the perspective of a physician-patient office encounter. The electronic standards include HITSP TP50, C76 and C151. The IHE standards from which these have been derived are RFD, DSC, CRD,

A patient enters the office exam room and Dr. Jones begins to complete the electronic medical record for the visit. A trigger (based on diagnosis or test result) in the patient's record alerts Dr. Jones that the patient is eligible to participate in the national registry. Dr. Jones invites the patient to participate and the registry form appears within Dr. Jones' electronic medical record. It is pre-populated with data from the CCD of the patient's electronic record. Dr. Jones only needs to complete any non-standardized data elements. If all elements are standardized, no additional work is necessary. He reviews the form and with the stroke of the keyboard, submits it in a secure and standard manner to the national registry data center. The integrated registry forms can also provide real-time links to decision support tools, patient education materials and even performance benchmark reports.

This scenario is already in practice. This is exactly what currently occurs for participants in the American Society for Plastic Surgeons program who are using an EHR that has implemented these open standards. Users report a reduction in work effort by approximately 80%.

These professional association programs have demonstrated some of the most remarkable quality improvement results to date. They are routinely updated as clinical science advances. Most of the programs have updates 2 or 3 times per year. Having a single source for the sophisticated electronic registry forms enables the association to modify data elements and quality measurements in a manner that would be difficult to maintain in EHRs through system by system coding efforts. Finally, these programs draw tremendous value from the aggregate data collected on a national basis. The trust and stewardship of the data rests with the national organizations. The methods described here enable an accurate and sustainable method for the re-use of clinical data from EHRs. Furthermore, these methods protect confidentiality and ownership of the aggregate data.

The good news is that these open standards already exist, have been demonstrated for use in registries by several of the leading EHRs through HIMSS interoperability programs, and are being used with excellent results. These capabilities are further described by Gliklich R, Dreyer N, Registries for Evaluating Patient Outcomes : A User's Guide, Second Edition, produced for the Agency for healthcare Research and Quality by our Outcome DEcIDE Center. The handbook is electronically available at AHRQ's website www.ahrq.hhs.gov.

We would like to encourage the committee to do three things:

1. Recognize provider participation in specified national quality improvement programs managed by specialty and patient organizations as fulfillment of the requirement for meaningful use quality reporting.
2. Create a mandate by which all EHRs would implement these specific open interoperability standards in their products.
3. Recommend a process by which the CCD can be updated annually with specialty developed data elements.

On behalf of Outcome and the associations that gave permission to present their programs here today, I thank you for this opportunity and look forward to your questions.

Terms:

CCD: Continuity of Care Document

CDISC: Clinical Data Interchange Standards Consortium

HIMSS: Health Information Management Systems Society

Integrating the Healthcare Enterprise (IHE) is a global initiative that creates the framework for passing vital health information seamlessly – from application to application, system to system, and setting to setting – across multiple healthcare enterprises. IHE does not create new standards, but rather drives the adoption of standards to address specific clinical needs. IHE Integration Profiles specify precisely how standards are to be used to address these needs, eliminating ambiguities, reducing configuration and interfacing costs, and ensuring a higher level of practical interoperability. IHE is now truly multi-domain with Integration Profiles for Radiology, Cardiology, Laboratory and Information Technology (IT) Infrastructure, which enable interoperability both within and across multiple enterprises. Three of the IHE standards include the following. (source: www.ihe.net)

RFD: Retrieve Form for Data capture

DSC: Drug Safety Content profile

CRD: Clinical Research Document

The Healthcare Information Technology Standards Panel (HITSP) is a cooperative partnership between the public and private sectors. The Panel was formed for the purpose of harmonizing and integrating standards that will meet clinical and business needs for sharing information among organizations and systems. Three of the HITSP standards are listed below. Note that HITSP's contract with HHS concluded on April 30, 2010. Dr. David Blumenthal, the National Coordinator for Healthcare Information Technology, thanked the Panel for their contributions. (source: www.HITSP.org)

TP50: Transaction Package 50 (same as RFD)

C76: Component 76 (same as DSC)

C151: Component 151 (same as CRD)

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