

Health IT Policy Committee Hearing: Panel 2

Remarks prepared by Jonathan Keller, Director of Data Analytics Central Utah Clinic

My name is Jonathan Keller and I am the Director of Data Analytics at Central Utah Clinic and the Managing Director for Central Utah Informatics. Central Utah Informatics (CUI) came into being in 2008 the direct result of our clinic's failure to qualify through claims for PQRI in the six months reporting period in 2007. We struggled as a clinic to get staff and providers to append the appropriate g-code to the claim. When the option of registries became available we jumped at the chance and were one of the 32 qualified CMS registries. We became a registry initially to report for our own providers but we started receiving calls from all around the country from providers needing help with PQRI reporting. We created a business model and have experienced great success as a registry. We submitted for about 4,000 providers including our own last year and have qualified as a Data Submission Vendor for 2012.

I would like speak briefly about 4 barriers to EHR quality data from my own experience of working as a certified CMS registry as well as from my day job with a large multi-specialty clinic.

1. Not all data is discrete or found in the recommended location

As a registry we work with groups all across the country, and we received a request from one particular group needing a report of hypertensive patients and their most recent blood pressure reading. Our initial report for some of the providers showed no blood pressure reading for their hypertensive patients and upon further research we found that they were documenting vitals in the note and not in the vitals or clinical findings section of the EHR. Meaningful Use has been a great help to us as data analysts because it is forcing providers and staff to document items and results appropriately. It is so much easier to query discrete data than to scan notes and documents for that same data.

Another example is from the clinic I work for. We have struggled in getting the left ventricle ejection fraction or LVEF for patients with CHF for our Cardiologists. The LVEF measurement can come from a myriad of different tests and currently only one of them sends discrete data to our EMR. All the other testing methods send data to EMR as a scanned document which is impossible to query. We had to create a tracking system so providers could log LVEF results so we could improve our data quality.

2. Measure specifications are open to interpretation

For the first year of meaningful use we had to use our EMR vendor's certified reporting tool in order to attest for the clinical quality measures (CQM). My initial review of their report showed some in-congruencies between how we calculate CQM's. The first thing I noticed was how low the denominator was for the diabetes measures for our internal medicine providers. I asked the EMR vendor about this and I was told that the provider had to update the patient's problem list during the 90 day attestation period in order for the patient to show up in the denominator. I responded that even if the provider ordered a hemoglobin a1c test and a lipid panel and checked for diabetic nephropathy during the course of a visit but failed to update diabetes on the patient's problem list then that patient would not show up in the denominator for that provider. I was told that was how it was set up and they would not be able to change it.

I believe we need to be consistent first and foremost but I also believe that data needs to be complete and accurate. By leaving a diabetic out of the denominator because the diabetic problem was not updated does not strike me as complete.

3. Need for a shift from pay for reporting to pay for quality

I have been involved in healthcare data quality for nearly 10 years and the number one thing to get physicians involved in quality efforts and improving quality and performance is to reward them for it. I applaud the effort of those behind the value-based modifier and the opportunity provider groups have of comparing themselves to a national benchmark in order to receive an increase to fee for service payments, but I think we need to do more and go further.

We need to move away from pay for reporting and towards pay for quality. As a registry we produce a feedback report for every client that submits data to us and some of our clients once we tell them that they have hit the 80% threshold for reporting and qualify for the incentive they don't even take a look at what the quality performance numbers are. I think by rewarding high quality providers we will also move towards better quality data because providers will pay attention to it and if their numbers are low then they will want to find out why and we can either modify the reporting to better capture the data or help them become better at documenting so results can be recorded accurately.

4. Not all providers have access to quality reports

I have mentioned this before but it is worth mentioning again that I am extremely grateful for the Meaningful Use program. It has made my job easier as a data analyst but it has also given many small and medium sized provider groups a first look at their quality data. Most of these groups can't afford to have a full time data analyst on staff or to purchase an outside vendor's software program that would produce quality reports. I think that goes a long way in improving the quality of quality data. It at least opens up the discussion and gets providers talking about and involved in quality. Before the advent of meaningful use for many of these groups this was not possible. Again I think

we need to do more and give providers real time access right at the point of care to quality data. If a provider knows that a diabetic patient on his schedule for the day is overdue for a test immediately without having to dig through the chart then that test can be ordered and the appropriate care dispensed.

It is exciting to see the new direction of healthcare and that quality data and performance is a part of that direction. If the healthcare industry can overcome the barriers to capturing quality data it will make it easier to report, measure, and reward quality performance and ultimately provide better patient care.

I thank the ONC and the Health IT Policy Committee for the invitation to appear before you today and with that I will conclude my remarks.