

Commentary Submitted to
Joint Hearing of Health IT Policy Committee (HITPC) and HIT Standards Committee (HITSC)
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By Panelist
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Good morning/afternoon. Thank you for allowing me to offer perspective on this important topic today. My name is Karen Van Wagner, executive director of North Texas Specialty Physicians – known as NTSP. We are an Independent Physician Association comprised of nearly 600 family and specialty doctors dedicated to delivering the best medical care to the residents of Tarrant, Johnson and Parker Counties in North Central Texas. Unlike some physician groups, NTSP is governed by a board comprised solely of local doctors and is managed by resident health care experts. Since its founding in 1995, NTSP doctors have dedicated themselves to delivering high quality medical care to more than 15,000 patients every work day. One of our core principles is that information is foundational to the way we practice medicine -- access to information leads to both better health care delivery and better outcomes for patients. As part of our objective to offer the best care for our patients, in 2010, linked with our technology partner, Sandlot Solutions, NTSP created a privately funded robust health information exchange, called Sandlot Connect.

If the intent of this hearing is to determine whether health information exchanges can serve as foundations for building a more effective and efficient health care system, I offer our experience as proof.

Prior to the launch of our community HIE, our physicians were frustrated by the simple lack of access to health information for patients even within our own group practice. This was a relevant concern because we care for thousands of Medicare patients, and older patients seeing multiple doctors and are sometimes not able to recall pertinent details about their care, such as whether they received pneumococcal vaccinations or what medications they are currently taking. The physicians recognized that better access to information could lead to safer and more effective care, and ultimately lower costs and improve patient compliance with physician recommendations.

In tandem with the development phase of the HIE, we made a concerted effort to increase utilization of EMRs across the group practice. Achieving the critical mass of EMR users to support the new HIE required a multi-faceted approach. For one, we recruited champions from across all subspecialties and commissioned them to evangelize others, which began to create the foundation of data needed to support the HIE. Based on our targeted outreach and training efforts across the community, we achieved adoption rates nearly twice the national average. And for our physician group, the adoption rate is greater than 90 percent and 95 percent of patients have opted in to have their information shared. We also made a significant investment in “gifting” 300 EMR licenses and training support annually, to motivate physicians to make the shift to digital records. As EMR adoption grew and physicians began achieving meaningful use, their appetites for the HIE experience were magnified. With EMR, they were able to more effectively communicate within the walls of their own organization. But with the HIE, they would attain access to information from multiple external sources across the provider community. With this capability, they would have the ability to effectively coordinate care and

truly measure outcomes. More than any external driver, the internal desire to improve patient care by having real-time, comprehensive patient information and clinical decision support tools through the HIE was the key motivator for the group to invest in rapid adoption of the EMR.

As the government and the private sector continue to expand the footprint of ACOs and medical homes, a worthwhile question is whether tools like HIEs can support the objectives of ACOs and medical homes, which at a basic level is more coordinated care. One key differentiator of our HIE is that it was originally created as a physician-driven exchange, rather than a hospital-driven HIE. The most commonly used functions are the receipt of episodic continuity of care documents from the various participants, and then the pushing (or subscribing of) summary CCDs in advance of any scheduled patient visit. However, given that many primary care physicians complain about the lack of information from specialists and vice versa prior to patient encounters, even this simple activity supports a basic goal of information sharing, a key element of care continuity. Even so, I will offer further evidence that HIEs can do much more.

Since the launch of the exchange in 2006, we have captured vast amounts of clinical information on more than 2.8 million patients across seven counties. The system has more than 2,400 active physician users with 40 community connections and 33 connected hospitals. There are approximately 3.8 million lab records and 8.9 million medications records stored within our exchange. We are connected to half of all radiology and lab services in the market, 100+ pharmacies, and 350+ interoperable electronic health records across three primary EHR platforms: ECW, Allscripts and NextGen. We support comprehensive bi-directional data exchange of clinical data between these platforms and push connectivity with portal access to our acute care partner, Texas Health Resources. Data transfers between EHR platforms and other specialty exchanges, such as pharmacy databases, occur in real time. Our enterprise data warehouse (EDW) and MDI capabilities support Emergency Department notifications, access to lab information, pharmacy details, allergy notes and immunization records.

We have plans to expand our technology offering nationwide and have begun work to redesign our care model to optimize care transitions and enhance care management for seniors and patients with chronic conditions. In our opinion, while I think we've accomplished a lot, our physicians and providers believe that we have just scratched the surface of leveraging real-time clinical data exchange.

What has been the impact thus far? You obviously know that the ER is one of the most expensive places to provide care. We asked ourselves if we could apply data exchange technology to help patients avoid ER visits. Through a pilot project, we demonstrated that the HIE alerts we provide to physicians and ACO preferred providers can equip the providers to offer better care to patients with chronic conditions, helping them to manage their illnesses and avoid health crises that might normally lead to an ER visit. Our Sandlot exchange also provides alerts to primary care physicians about any ED visits that do occur so they can coordinate with hospital physicians in the event of an emergency admission, and to schedule follow ups.

Sandlot also enhances our Discharge Transitions Program, which is the care transitions program designed for Hi-Risk Members and ACO Beneficiaries to help them move from acute to post-acute care settings. Sandlot Connect provides important information, including medication history, details about past hospitalizations, discharge summaries to ensure accurate care planning and information on specialty physicians who need to be involved in patient care outcomes.

One of the major obstacles to effective integration of any health information technology tool into clinical use is how easily it can be incorporated into the clinical practice patterns of physicians and

nurses. Because Sandlot was designed by physicians, it was created with clinical workflow in mind. Physicians and nurses in our practices do not need to exit their practice EMR systems to retrieve HIE alerts or data. The information is integrated into existing work modules. This means that the information we intend to capture is always captured and available for users. This enables providers to have prospective, concurrent and retrospective views of patients' clinical status, and enables physicians and nurses to input real-time information into the HIE records.

Based on our use of this technology, we are convinced that health management platforms that rely on retrospective medical perspectives alone are a major reason why our nation has not significantly improved cost or quality over the last two decades, an era when health IT has flourished. Medical claims data, obtained either from Medicare or private insurers is insufficient to guide improvement. Clinical data, because of its greater specificity and timeliness provides more value both for individual care and population health management. Claims data is useful in filling the gaps beyond the clinically-connected domain, but isn't sufficient in and of itself. Claims-based care management has not yet reduced total cost associated with patient care; however it is our belief that the combined clinical and insurance data will provide the breadth and required timeliness of the data to finally reduce costs while improving quality. HIEs can pull these elements together. HIE gives providers the full view into continuum of care, which helps us begin to change our focus from episodic or single encounter perspective toward a long-term focus on health.

To help you understand the impact our HIE is having on patient care at a practical level, I want to offer an example of how it impacts a single example, and then an example of how HIEs impact broader population health management activities.

A 64 year old female patient, with primary biliary cirrhosis and concurrent alcohol abuse showed up at a physician office. She was not compliant with office follow up for two years and was manifesting jaundice and confusion consistent with mild hepatic encephalopathy. The patient's confused mental status prevented a reliable history and the daughter was unaware of medications or pertinent medical history. Our health information exchange (HIE) provided a wealth of clinical information at the time and place of service, allowing for a more accurate assessment of the patient's medical status during the office visit and prevented the expense of duplicate diagnostic and imaging studies. The fact that the HIE housed previous laboratory results meant the care team had a baseline for comparison of subsequent studies. From the medication list it was determined that Doxepin was a likely contributor to the patient's progressive encephalopathy and it was discontinued. Costs were reduced or saved as a result of the information being available at the time of visit with her Gastroenterologist. If the diagnostic tests had been ordered, the costs associated would have been \$15,191 at the Medicare Fee schedule for Tarrant County, Texas at that time and the commercial insurance reimbursement (assumed at 140% of Medicare) within the community was \$24,086. Since the needed clinical information was available via the HIE these expenses were not incurred.

Now let's look back at the macro level benefit of the HIE. In the fall of 2010 NTSP launched a pilot program focused on Discharge Transitions to improve the continuity and quality of patient care following a hospital stay. The focus was Medicare Advantage Health Plan Members. Our goals included: promoting effective transition of care at hospital discharge; reducing 30-day readmissions; improving communications among caregivers; improving medicine reconciliation; and ensuring timely follow-up with the patient's Primary Care Physician (PCP) or Specialist. Our HIE was specifically designed to date tracking and data aggregation capabilities, meaning no additional effort was required by staff teams to monitor program progress. It goes without saying that the need to apply "additional effort," which entails costs and time, is often the obstacle to implementing many improvement programs. An HIE does

the mundane work for providers so they can do the medical work. Two years later, there have been more than 1,084 patient participants in the program. Results to date are very positive and the program has overachieved against each target goal as follows:

Indicator	Target	Results
PCP / Spec Follow up visit within 30 days	85%	99.5%
D/C notes / summaries available to PCP/Specialist prior to patient's F/U visit.	90%	100%
Patient Re-admission Rate within 30 days SAME CONDITION	5%	2.71%
Patient Re-admission Rate within 30 days OTHER CONDITION	12%	9.38%

As indicated, based on our success with SandlotConnect in Texas, we expect to grow the exchange by 30% in 2013. This summer we will begin roll out of a new platform that is faster and more IHE standards compliant than our current platform. It is our opinion that EHR vendors are not moving to IHE standards fast enough, which can only hinder HIE adoption by providers. While some large CIS vendors are very slow to support exchange activities, our philosophy is to create more open connections across communities. We have interfaces to 15 hospitals, radiology vendors and national lab vendors. The interface is a bi-directional transfer of information from the HIE to the EMRs and from the EMRs to the HIE. We transfer continuity of care records and continuity of care documents, which include vitals, problems, procedures, medications and allergies.

For health care to continue the transformational journey, the industry must support the merger of clinical and claims data together to give care managers a complete perspective. With respect to how the government can support this evolutionary journey, we would suggest simplifying the notion of consent and minimizing the variety of disclosure rules, to allow further sharing of information, including information about mental health and substance abuse. Specifically, we would ask the government to expedite the adoption of IHE standards across healthcare platforms. It's happening, but too slowly. Mandate that by January 1, 2015 all laboratory diagnosis be delivered utilizing LOINC standards. Mandate that all hospital CIS systems generate a "just admitted" notice so that community providers who might be connected via any EMR system will be notified. Mandate that all pharmacy systems communicate with HIEs and provide data free of charge. Most states do require submission of claim-level or coding-level information, but not care-sourced clinical information. If a provider is using an EHR, the provider should be able to send clinical data for quality evaluations to an HIE that is equipped to let any subsequent provider see that data, no matter the EHR platform it is being viewed on.

I appreciate the opportunity to share our positive history with our health information exchange. Based on that history, I can validate that HIEs will help guide better health care delivery and better health care outcomes for patients, if HIEs are supported as community owned resources, rather than shielded as proprietary tools.