Testimony of Simon Karp, 1/15/16

INTRO

Good afternoon. My name is Simone Karp, and I serve as a Vice President of Premier, and the Chief Business Officer for the Premier subsidiary, CECity. Premier is a leading healthcare improvement company, uniting an alliance of approximately 3,600 U.S. hospitals and 120,000 other providers, including some of the nation's largest physician practices. Together, we help deliver measurable improvements in care through quality measure reporting, cloud-based professional education, large-scale provider collaboratives, including with CMS, and other quality improvement technology solutions.

We appreciate the opportunity to address the Certified Technology Comparison Task Force today.

As you know, EHR innovation is no longer solely driven by technological progress, as so much more is now riding on the successful exchange of meaningful data as a result of federal policies. EHR data will need to seamlessly flow to external quality-focused IT systems, such as CMS qualified clinical data registries, known as QCDRs, which have demonstrated the ability to successfully drive improvement in both quality and cost. However, the QCDRs will need to increasingly rely on standardized, accurate and timely data across multiple EHRs for providers to be successful under value-based and alternative payment models. It is only by measuring and benchmarking performance beyond the four walls of a single organization can we begin to help providers identify comparative gaps in performance and prioritize quality improvement efforts.

So the question becomes, how do providers know which EHR system is going to put them in the best position to easily, cost-effectively, and accurately deliver the timely data that they need to improve the quality of care they deliver to their patients, and at the same time enable them to succeed under these high stake initiatives?

At Premier we have identified the following three pillars that we believe EHRs must support, and an effective comparison tool must clearly convey, for providers to successfully engage in the emerging quality enterprise.

These include:

1) High Fidelity Data;

2) Bi-Directional Data and Information Exchange; and

3) Timely Data.

Let's look at each of these in a little more detail.

<u>High Fidelity Data</u>

The first and perhaps most important capability is what we refer to as "high fidelity data." In other words, how "accurate," "valid" and "organized" is the data that is being aggregated by the EHR from its database, packaged into a standard file exchange format and exported for use in various quality programs.

In our experience data fidelity is highly variable across EHRs, and even across different installations of the same EHR, and currently there is no way to tell the good from the bad in advance of receiving and validating the data.

There are a number of root causes for this, but regardless of how and why it happens, at the end of the day, when a measure under the PQRS program or an alternative payment model requires a specific data element, we need to make sure that what is in that standard file is the right data, in the right place, in the right format, at the right level of attribution, every single time.

Without this assurance of data fidelity, measurement may be unreliable, most often to the detriment of the provider, aggregate benchmarking becomes difficult to the detriment of the profession, and our ability to identify the true gaps in performance falls short, limiting our ability to target quality improvement activities where they are most needed, ultimately to the detriment of the patient.

An EHRs ability to validate data fidelity across these dimensions, prior to export, and to quantify this capability for presentation in the EHR comparison tool, would be our top recommendation.

Bi-Directional Data

Our second recommendation is that EHRs should support "bi-directional data and information exchange".

We often hear about interoperability related to the exchange of data between EHRs.

However, in order to drive quality improvement and power alternative payment models, we also need to seamlessly send data from the EHR to external quality-focused IT systems, such as Public Health Registries.

And, we need the ability to easily return information generated from the use of the data by these quality IT systems, back into the EHR for presentation to the provider in the workflow, where they can become actionable and serve as a foundation for building a continuous learning health system, as recommended by the National Academy of Medicine.

We believe that this is quite possible through the use of standard Application Programming Interfaces, or APIs, designed for moving data at scale for use by quality-based systems and registries, such as those used in public health, quality improvement and alternative payment reporting.

The ability for an EHR to bi-directionally exchange data, and to do so using standard API technology, is our second recommendation.

Timely data

Finally, our third recommendation relates to the EHRs ability to generate and readily exchange the required, high fidelity data in a "timely" fashion.

As we shift from annual quality reporting programs to alternative payment models, clinical data registries, and other continuous quality improvement initiatives, the need for near real-time data becomes imperative.

Therefore, our third recommendation is that EHRs be capable of supporting data aggregation and exchange at a cadence that meets the needs of the emerging quality programs. By presenting

these capabilities through the EHR comparison tool, providers will be able to better understand which programs they are prepared to participate in, in advance.

<u>Conclusion</u>

Again, on behalf of Premier, I would like to thank the task force for the opportunity to participate in this discussion.

We look forward to working together to improve the infrastructure of our nation's quality enterprise, and to help communicate these key differentiators to our national provider network.