GREENWAY

Testimony of Jason Colquitt

Before

Health Information Technology (HIT) Policy and Standards Committees

Hearing on Clinical Quality

Panel 4:

Electronic Health Record Vendor Perspectives of Necessary Components of Quality Improvement

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Thank you very much to the HIT Policy and Standards Committees for an opportunity to speak. My name is Jason Colquitt, and I am a Vice President with Greenway Medical Technologies (Greenway) based out of Carrollton, GA. I know that we all bring different lenses to this hearing, and I would like to take a moment to outline my vantage point prior to engaging in the topic at hand. This will hopeful allow you to better understand my views and perspectives.

The lens of Greenway:

Greenway is a provider of integrated electronic health records (EHRs), practice management and interoperability software solutions. Our solutions are leveraged by various ambulatory settings to include 30 specialties and subspecialties. Over 33,000 providers use our solutions to deliver care and capture the clinical, financial, and administrative information of over 20 million patients.

My focused lens at Greenway:

At Greenway, I have been blessed to watch and lead in growth for 12 years. My current focus consists of leading a division whose platform supports analytics/business intelligence, care coordination, quality, as well as research. We have gone through the process of supporting 44 Stage 1 Clinical Quality Measures (CQMs). We also have been a qualified CMS registry under the Physician's Quality Reporting Initiative (PQRI) and now System (PQRS). This year under PQRS, we will support 217 measures under both registry and direct submissions vendor (DSV) methods.

My lens across the industry:

I have had the privilege to cross-pollinate with many of my EHR/HIT brethren in the standards arena, where I previously chaired Integrating the Healthcare Enterprise's (IHE) Quality, Research, and Public Health (QRPH) committee as well as foundational work in this arena participating on the Healthcare Information Technology Standards Panel (HITSP) Population Perspective Technical Committee. In addition, I currently serve on the Executive Committee of the HIMSS Electronic Health Record Association (EHR Association). The EHR Association is comprised of the nation’s leading EHR companies.

Views of clinical quality:

As I reflect on the past as a springboard for the future, I think it is important to note the time spent on validation. Rightly so, in order to fully test the algorithms, permutations, and calculations many hours went into each measure on which we certified/ qualified.

Could there be a better way? What if the clinical quality engine could easily be seeded with test data in a standard format vs. manual set-up? What if there was a test harness to validate the output against a schematron? What if the measures themselves were fully executable vs. writing custom queries? Finally, should our output even be aggregated, or should we be sending the patient level data?

The next reflection is around the dependence of the provider on the EHR vendor. Amongst a large majority of our providers we were their source of truth. They relied on us to guide them in the ways they should report. We had to outline and train providers as to what data points drive each measure. This also meant resolving the various programs and detailing what measure was reported for which program. Alignment across programs is a "must" going forward for the sake of the provider, and, the sooner the better.

Maintenance of all the codes and value sets was quite challenging across all the various measures. If an update to a measure occurred, it was no small update. A centralized shared repository would help defer the stewardship and the maintenance burden away from the EHR and could simply become a by reference pointer within the measure itself.

Another thought was the naive notion that a provider would simply use the EHR at point-of-care with no changes, and we would be able to glean all measure calculations. For some outcomes measures this may have been able to work. However, in many measures, there were exceptions and questions that need to be prompted as the data points were either not normally captured or captured in a non-discrete fashion.

Can we build our systems to get away from the checkbox measure? Should/could we drive a provider toward the answer? In order to properly complete a measure, many times, clinical decision support (CDS) is needed to drive appropriate data capture. If we could construct our measures to be executable, then maybe we could allow for CDS to be driven off the same infrastructure to allow for prompts and reminders to collect the appropriate data.

At Greenway, we can boldly say that feedback mechanisms such as a dashboard actually work. This was our best-selling feature around our Meaningful Use Stage 1 functionality. By visually causing peer pressure, it was amazing to see how well a provider self-corrected. Allowing providers the opportunity to see their progress is a huge driver to successful quality reporting performance.

In the not-too-distant-future, do we foresee a clinical quality measure that is fully consumable and executable? Is that measure plug-and-play requiring no human intervention? Are there corresponding consumable and executable CDS?

A fully measure-aware EHR should be our goal!

In closing:

I want to thank you for this opportunity and your dedication to quality measurement and CDS. I hope that my views will help stir ideas and thoughts that can be leveraged. I look forward to the Q&A to follow. Thank you very much.