Clinical Quality Hearing of the

Health IT Standards and Health IT Policies Committees

Testimony by

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Good morning. My name is Janice Nicholson, and I am co-founder and CEO of i2i Systems. i2i Systems is a 12 year-young company dedicated to helping the health sector make the best use of their data through smart technology – technology that supports easier and greater access to data and improves the efficiency of the care team staff.

Our 200+ clients deliver care at over 1000 sites in 29 states and include community health centers, health center controlled networks, physician group practices, hospitals, medical colleges, and public health departments. We have learned from them, struggled with them, and have done our best to understand health care processes so that our solutions can best support their clinical and quality improvement work. Our mission statement "Creating Healthier Populations" has consistently guided our product and service development and we have never wavered from that commitment.

We are honored to be here today to share our thoughts and suggestions on behalf of all our clients, most notably the hundreds of health centers and small primary care practices that we serve.

First, let's go right to the heart of the matter: What factors limit Health IT's ability to support quality measurement and quality improvement? My response is based on field experience in supporting 100s of clinics and practices who are using more than 30 different PM/EHR systems. I would like to tell you that we have figured out why health IT investment has not resulted in more dramatic improvements to outcomes of care and that we have the solution, the silver bullet. We do not.

What I can share with you are three of the top challenges we have experienced in helping organizations realize benefit of health IT adoption.

The first challenge is that of standards and interoperability. EHRs say they interoperate but what they don't say is at what level. Much of the data in EHRs about patients is customized, unstructured data. Even within the same EHR, templates allow a patient's medical data (e.g., smoking status) to be stored in different locations of the database using different representations. This means that while the definition is the same, the information available is not. This lack of EHR vendor standardization and inability/unwillingness to share customized, unstructured data cripples efforts to address meaningful use and severely limits analytic capability of EHR data.

The second challenge is that EHRs do not fully support MU requirements. Health IT analytic capabilities are currently not evolved enough to support tactical, operational and strategic population health management for continuous improvement. This hampers organizational leadership, management and even care teams in proactively monitoring and improving performance. To meet MU stage 3, organizations need tools that will support long term, sustainable change. A simple example of this is HbA1c testing for diabetic patients. Evidence based guidelines suggest A1C screening for a diabetic patient should occur at least twice during a year-long period. This simple adherence tracking for one patient becomes complex very quickly when managing population health for thousands of diabetics.

The third challenge is lack of incentive to achieve higher levels of performance. We often see organizations drawn to our solutions mainly for required reporting to payers. We encourage organizations to leverage our tools to their fullest but, sadly, many are satisfied with threshold performance since there are not enough incentives to

drive up performance. This speaks to lack of a data-driven culture incented to measurably improve health outcomes.

In closing, I would like to summarize three opportunities that arise out of the challenges just presented:

> **First**, health IT vendors must provide clinics open access to their data and remove barriers to standardization and interoperability. Performance can then be measured in a reliable way and shared across the health system.
> **Second**, we need to face the reality of what EHRs currently deliver. There is no single, comprehensive, all-inclusive Health IT solution that will meet everyone's needs today and in the future. We have to help providers understand the intelligence tools they need so they can plan and budget for what will be required to monitor, improve and sustain health outcomes.
> **Third**, we need increase the percentage of revenue directly related to pay for performance. Organizations need to be incentivized for behaviors that drive change.   This will naturally catalyze the quality lifecycle that results in high performance.

We can be optimistic if we address these opportunities. Success is within our grasp and it can come at a price that you, me, the nation can afford.