

Statement of MinuteClinic, Inc.
Before the
Institute of Medicine/National Research Council Committee
On the
Review of Standards Activities of the Office of the National Coordinator
Of Health Information Technology (ONC)

September 17, 2007

Trish Hughes, EdD, CRNP
Christopher Ross, MBA

On behalf MinuteClinic, I am pleased to provide our views on data and technical standards in health IT systems nationally, with a particular emphasis on how the standards process can best support interoperability.

I am Trish Hughes, EdD, CRNP (certified Family Nurse Practitioner), and Director, Guideline Formation and Implementation for MinuteClinic. Joining me in these remarks is Christopher Ross, MBA, and Chief Information Officer of MinuteClinic, who was not able to be here personally to help submit these remarks.

MinuteClinic is the pioneer and largest provider of retail-based medicine. We provide a limited scope of medical services in convenient locations (pharmacies, malls, office buildings, and grocery stores) with extended hours on evenings and weekends. Our care is provided by board-certified Nurse Practitioners and Physicians Assistants, who practice in collaboration with physicians. We have had over one million patient visits, with 99% patient satisfaction levels, in our seven years of operation. We are fully accredited by the Joint Commission (formerly JCAHO). All of our care is managed with an Electronic Medical Record system. Today we operate over 260 clinics in 22 states, with substantial additional growth planned. We are a wholly-owned subsidiary of CVS/Caremark.

Our comments will focus on the need for clinically and commercially viable medical exchange standards for the primary care community.

MinuteClinic firmly believes that patients should have a medical home, and that continuity of care improves the quality of care. Retail-based clinics, like pharmacies, laboratories, outpatient surgical centers, imaging facilities, emergency rooms, urgent care centers, and others, are all important parts of the system of primary care. More must be done to make sure each of these organizations provides data to the patient's medical home.

To support continuity of care, MinuteClinic provides each patient with a written visit summary (sample attached), and provides the same summary to the patient's medical home when the patient identifies one. (For those without a medical home we provide a list of practices able to accept new patients.)

Today our communication with medical home physicians is on paper. We believe we can substantially improve patient care quality if we could communicate electronically.

As we developed our approach for medical record exchange, we looked first to see what was being used by physicians who would receive our records. Most of our visit summaries are sent to family physicians and pediatricians. The American Academy of Family Physicians, in particular, has provided strong and capable leadership in encouraging their members to adopt electronic medical record systems. They have also encouraged the development of standards for interoperability that are both clinically appropriate and sized appropriately for primary care practices and the vendors who

supply EMRs to family physicians. AAFP has provided crucial leadership in making the ASTM-balloted Continuity of Care Record (CCR) format viable, and widespread.

In early 2007 MinuteClinic converted all of its medical communication to CCR format. We made this commitment to CCR for several reasons:

First, the CCR is essentially complete and is being adopted. Most EMRs being used for family practice support CCR. Most PHRs use CCR. Substantial industry and media attention has been focused on plans by Google and Microsoft to provide consumer-facing health products, and both have announced support for CCR.

Second, the CCR works equally well for EMRs and PHRs. Most agree that patient engagement is crucial to improved health. Many believe that patients will have a key role in managing the exchange of their own health data. There is substantial power in adoption of a single standard that works well for both patient and provider. By contrast, the competing patient summary standard is the Continuity of Care Document (CCD) which has and will always have its roots in the HL7 standard. HL7-centered organizations have enormous business and clinical complexities. We are concerned that as larger HL7-based organizations work through their challenges, it will be extraordinarily difficult to maintain an equal focus and commitment on a patient-centered, transportable record. At a minimum, we urge the ONC to support the Clinical Document Architecture (CDA) interchange work so that the CCR can remain the standard of choice for PHRs and ambulatory health EMRs.

Third, the CCR standard fits the economics of primary care. It can operate as a compact patient summary on its own, without expensive and complex implementation of broader and deeper standards and protocols.

Altogether, we believe that the market has reached a tipping point. The market has evaluated, tested and is adopting CCR. We believe it is important for ONC and HITSP to encourage and accelerate this market-based, clinically sound, broad-consensus standard.

We thank you for the opportunity to submit remarks.