Physician Burden Issue: Data Lock and lack of interoperability.

Issues:

There is no standardization in EHR systems as to the definition of an Encounter and Episode of Care are.

For example

A patient presents to a provider.

The provider documents the Review of Systems

The provider documents a neurologic evaluation in the neurologic evaluation template of the EHR

The provider documents an orthopedic evaluation in the orthopedic evaluation of the template of the EHR

The provider takes an X ray and documents that in X ray template of the EHR.

The provider writes a note and in text format indicates the other examinations were completed.

The provider then refers the patient out to a specialist.

None of the information in templates that were filled out are part of the ‘bundle’ shared.

The same provider – at some point in the future wishes to change EHR Systems.

1. There is no way to be sure that the information from that encounter above will be able to be transferred to the new system either accurately or completely.
2. The provider may have the option of getting a ‘data dump’ from the original EHR but there is no guarantee that the data entered into the templates will be part of the data dump. The provider may be required to pay high fees for this data dump depending upon the contract that was signed.
3. The provider may be required to continue to pay a monthly fee to the EHR vendor for a tool that allows the provider to view the patient data that was entered into the old EHR system depending upon the contract with the old vendor.

There is no requirement on the part of cloud based EHR vendors to maintain patient data for doctors that have ‘left’ the cloud EHR.

Doctors can leave a cloud system for a number of reasons:

1. The Doctor passes away
2. The Doctor retires
3. The Doctor changes EHR Systems

If somebody is not paying the original EHR vendor then the records can be deleted. This results in the records not being accessible. This creates a HIPAA issue and is a violation of patient rights.

Many of these problems are difficult to solve, in that they involve civil contracts between Doctors and their EHR vendors.

For example, custom templates for organ or system specific exams do not have published standards and thus it is impossible to develop a standard for exchanging the data in these exams. One possible solution is the use of specialized registries for system or organ specific examinations that will publish a standard for submitting the data to the registries. If this standard is adopted by certified EHR systems, then the exchange of this information between providers and moving the data from one EHR system to another would be facilitated.

Not every EHR would be interested in supporting every organ or system specific template. This is where specialty specific certification could help to ease burden for physicians. If specialty specific EHR systems were certified to support specialty specific templates, then the transfer of information from one system certified for a specialist to another would be facilitated.

In addition, as part of the ‘certification’ or a specialized registry having the registry publish an implementation guide so that applications could be developed for EHR systems to enable systems that are not specialty certified to import the templates and have the information in the templates available to the provider receiving the document would facilitate communication between specialists and other doctors. Those doctors who are receiving the data would not need tools to allow them to create the templates, just a method of viewing the information they receive.

To turn these specialized registries into repositories of information that could be queried by any EHR would allow a primary care doctor or specialist to retrieve all episodes of care that relate to a specific organ or system and create a longitudinal record of the patients care for that problem.

That same registry, as a repository of information could be a source of data to populate a new EHR installation when a provider switches to a new EHR provider.

The registries of this nature would also help to protect patient rights in that the information in the registry would persist even if the individual EHR installation that sourced the information is no longer operational.

This approach also protects against data loss when a cloud based EHR system ‘goes away’. The of ‘de centralizing’ the data provides redundancy and protection to all stakeholders in the Health Care Ecosystem.

To try to get all EHR systems to support all workflows would be trying to ‘boil the ocean’ but to take it in an incremental fashion and engage multiple stakeholders including clinicians and clinical societies in the process will allow for deployment of inter-operability and reduction of clinician burden in a targeted manner. I will then be up to the individual clinicians to engage with technology vendors that have implemented the interoperability that meets their needs.

Synopsis /Recommendations:

1. Modify the certification program to include specialty certification. This certification includes certifying that the EHR meets the needs of the specialist. It should also allow for specialty specific systems to NOT include features that are not of clinical value or use to the specialty that the software is certified for. This will ease the burden on developers of specialty specific software, encourage more innovation and possibly encourage new developers to get into the business of certified EHR Software. This would ease the burden on clinicians in that they would be able to obtain software that is tailored to their specialty and supports their specialty specific workflows.
2. Adjust the QRDA certification program to require that QRDA submitted measures be published with Implementation Guides that allows an EHR vendor to know exactly what data fields are required for submission of the QRDA developed quality measures and allows the EHR vendor to develop an end to end interface with the QRDA for submission of the specialty specific quality measures. This would ease the reporting burden for clinicians that wish to participate in the Quality Reporting system both from the perspective of capturing the data and the perspective of submitting the data to a registry.
3. Encourage QRDA’s to become data repositories that can be queried by EHR systems to enable better enable interoperability, continuity of care and longitudinal care. This will ease the burden on providers in terms or getting access to patient information and making clinical decisions.
4. Encourage payors to interface with registries to access quality of care information so that providers can successfully obtain prior authorization for care adjudication of claims and participation in pay for performance programs without any additional data entry or button clicks further reducing the burden on providers.

Once again the implementation of such an infrastructure, in addition to the benefits detailed in the itemized list above, will:

More easily enable providers to move from one EHR system to another with a minimal amount of cost, effort and data loss

Protect the vital patient data from being lost to the Health Care community should a provider or EHR vendor go offline