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Hearing on "Achieving the Promise of Health Information Technology: What can Providers and the US Department of Health and Human Service Do To Improve the Electronic Health Record User Experience?"

Increased user adoption of electronic health records (EHR's) in clinical practice has not led to universally improved provider experience. Complaints of increased time burdens on the practitioner, loss of provider interactions with patients, and frustration with new requirements and changed workflows dominate discussions among providers even as the capability of EHR's to reduce errors and improve communication has grown. Federal action in the American Reinvestment and Recovery Act has pushed the adoption of technology in medicine in a way only wistfully contemplated in the past. The major tenets of improving quality, reducing errors, engaging patients and families, and making important information available appropriately, are almost universally applauded. Most would agree that despite the promise of the effort, there is much room for improvement in the provider user experience.

Three federal actions could improve the overall user experience by changing the environment in which these activities take place.

Recommendations:

1) Encourage development consistent with new clinical work flows by adjusting the required documentation for quality and billing. The current information workflow and documentation requirements are largely based on paper documentation efforts. For example, having providers place their initials on outside laboratory documents was a way of ensuring that providers did the work of intellectually engaging in the review and interpretation of important patient data. This type of activity was critical for ensuring that work was appropriately performed and a version has found its way into much of electronic documentation. Checking boxes to show that data was reviewed, or that tests were performed, or attestations of agreement with documentation performed by others on the healthcare team place unnecessary burdens on providers and do not substantially improve the care. It also lessens the value of providers practicing at the top of license. As the industry switches from volume to value the importance of documentation as a check and balance should lessen and providers should be rewarded more for expected outcomes. Documentation should consist of gathering the necessary elements for continuity of care – as a reminder to providers of the care provided on a certain date and time. Documentation in the new workflow should be a product of the care delivery. EHR's are becoming capable of constructing care documents as a product of information gathering, but this effort will be stymied by burdensome documentation requirements.

2) Set tight standards for interoperability and standardize terminology. One of the important value propositions for providers in the digital age is the free flow of information. Having key clinical data from all points of care has been a challenge for decades and the speed of future clinical improvements will depend on our ability to aggregate data from disparate clinical systems. The Office of the National Coordinator of Health Care Information Technology, currently under the direction of Karen DeSalvo, has been a champion in this space. They have recently published a 10 year interoperability plan that outlines a way forward. Adopting and accelerating the standard will help meet this challenge. ONC should not unilaterally set the standard, but could both convene the appropriate stakeholders where necessary and most importantly, select the specific standards. For example, clinical continuity of care document (CCD) standards have been developed, but they are not necessarily compatible. A vendor may produce a certified CCD, but this does not mean that another vendor can translate it into an understandable format. A more specific standard would help in this regard.

   Some of the problems rest in the fact that there are many areas of medicine that don't use truly standard terminology; therefore, setting a technical standard will not fix all issues in this space. For example, in laboratory, Logical Observation Identifiers Names and Codes (LOINC) give a standard format, but variance still exists in whether all laboratory values in all clinical systems maps to this format or any single format. The lack of full standardization leaves providers to input discrete data into their system, without getting the benefit of cross communication between systems.

3) Match patient engagement goals to markets; the effort should be about making choices available. Much effort across the country has been spent on moving the adoption needle on patient engagement technology. Making medical records digitally available to patients, improving on-line access to providers and information, and sending information digitally to other care givers has been the focus. This effort has most recently been measured not by availability but also by adoption. The question on this effort is not the inherent value of adoption, but the relative costs. As the information provided becomes more valuable patients will use the tools provided.