

HIT Standards Committee - Implementation Workgroup
Hearing on Adoption Experiences – Oct 29, 2009, 9am – 4pm
Panelist Questions for Comments

Provider- Louis Spikol M.D.-2 provider Family Medicine office-part of Lehigh Valley Physician Group, Allentown, Pa.

- What business problem (e.g., clinical issue, health outcomes problem, etc) were you trying to solve with implementing interoperability across organizational boundaries? What standards did you use and why? What were the outcomes you were looking for? Were these outcomes achieved?

The “business problem” that I was endeavoring to solve over the past 10 years with the use of health information technology and electronic health records include the following:

1. In general, provide safe, effective , efficient and evidence-based care for my patients.
2. Establish a central computerized electronic health record containing the appropriate patient information to accomplish number one above.
3. Establish and refine a digital workflow routine whereby patient information comes into the electronic record in a digital format and is quickly routed to the appropriate places in the electronic health record.
4. Establish a physical patient workflow routine that is facilitated by a refined digital workflow routine as mentioned above.
5. Establish effective and efficient digital communication routines with any entities that would have information about my patients. These would include hospitals,pharmacies, labs, ancillary services and other physician offices.
6. Establish Web portals whereby patients can access their clinical information as well as communicate with me and add to their clinical information.

As I suspect with most physicians who see patients on a daily basis and are not part of organizations providing them with any type of executive power, I have no ability to choose and/or implement any type of standards. The type of things that affects me,my office and patients most are outcomes. I am overjoyed if laboratory data, hospital data and information from other physicians sharing care of my patients with me can automatically populate my electronic health record. Mostly I am at the mercy of my hospital system, the laboratories and the vendors with respect to the ability to make these things happen as well as the cost of making these type of connections occur seamlessly.

I would say that approximately 50% of my desired outcomes have occurred over the last eight years with progress slowing down substantially over the past few years. My office has successfully set up digital links to the hospital, laboratory as well as ancillary studies (within the hospital). We have communicated with patients via a web portal over the last

8 to 10 years, but the integration with the electronic health record portion has been slow. The communication with specialty offices in a digital format, even though I am part of a large hospital system, has so far mostly disappointing. The ability to communicate in a digital format with physicians or subspecialty physicians outside the general area or outside my system has been nonexistent so far.

- Were there challenges associated with trying to implement standards between large entities with significant IT capabilities and those that were less well provisioned? What compromises had to be made?

The challenges our office has had with connecting with various entities has always been the necessity to wait and the inability to greatly influence any of the larger entities that affect our “digital life within the office”. Thus we are at the behest of our hospital system and the external laboratories and other entities as to when and how digital connections are made. Additionally, the extent, effectiveness and efficiency of these connections has not always been optimal. We will often accept the “good enough” solution as long as it does not cause us more work with the hope that these solutions will be improved in the future. (Which unfortunately has not always happened).

The amount of paper coming in through the mail and through the fax machine that subsequently needs to be converted into digital format and put in the proper place within our electronic record continues to be an area of disappointment for me.

- What special considerations should be taken into account for enabling providers in small practices (where adoption has been lowest and IT capabilities may be lacking) to have the interoperability necessary to achieve the meaningful use goals? What is the best way to overcome their specific challenges?

That's easy-this may sound blunt, but 2 concepts are of paramount importance-
DON'T MAKE ME THINK
DON'T MAKE ME PAY

Providers and small practices at this point in time are maxed out. They are working full out to take care of their patient load and those that are running their own practices are maxed out in trying to survive the current economic environment. This is especially true of primary care practices.

1. DON'T MAKE ME THINK-interoperability for physicians should be easy to establish, easy to maintain and transparent to daily activities. That is, it should set up quickly, work properly, encompass the largest amount of interoperability possible and work transparently on a daily basis.
2. DON'T MAKE ME PAY-at least don't make me pay too much. Physicians see interoperability at this point in time as helping other entities such as insurance companies, hospitals etc. more than the physicians and patients. Costs that are onerous for small offices have been and will continue to be a barrier for interoperability.

- Did implementing interoperability between organizations help you achieve your goals, or did it inhibit progress toward achieving your goals? What role did the standards play and what was the rate of adoption and the impact on overall costs?

Interoperability that is effective, reliable and transparent has always helped our office achieve significant health information technology goals. Since my office exists in the larger environment of the hospital system, we are

somewhat removed from the interplay of standards and costs with respect to implementation of interoperability, although I suspect they played a significant part. Our office, within our hospital system, is in the early process of changing from one electronic health record that has been adopted completely by the family medicine department to another electronic health record, presumably because interoperability will be enhanced with this new system. Many of the hospital's other databases reside within this new system.

- What is an example of your greatest success and your most frustrating issue from the implementation? What would you have done differently based on this experience if you knew what you know now?

Our greatest success has been establishing a paperless family medicine office as well as establishing a reasonably effective and efficient workflow to go along with this paperless office. In addition, there is no doubt in my mind that the use of medication databases and the printing and faxing of prescriptions to pharmacies has made it infinitely safer for our patients.

Our greatest frustration has been the lack of progress over the last three or four years in moving our system forward. Responsibility for this is shared by the chaotic progress with respect to health information technology in this country, issues within our hospital system and certainly issues within our office. It's my opinion that the important thing with regard to these issues is that they are primarily social, proprietary and bureaucratic rather than issues with respect to immature technologies or platforms.

I would have done many things different knowing what I know today-mainly being more proactive in many areas.

- What advice would you give to help others mitigate problems or accelerate adoption of interoperable health information technology in order to improve health care quality and cost-effectiveness?

My advice to other small physician offices has been and continues to be-

1. Most physicians and their offices concentrate on the physical process of electronically writing patient encounters that have previously been done in paper. The concentration should occur in the area of interoperability, communications, collaboration and connections. The process of writing patient encounter notes with electronic health records is usually no faster and in some cases slower than paper records. The real way of gaining traction is to achieve operational efficiencies in your office with communication, collaboration and database operation and structure. Physician should look at their office as a "system" rather than having a tunnel vision viewpoint that the only thing that matters is what they do in the examination room. Interoperable health information technology has the capability of bringing all the players in health care to bear-primary care physicians, specialty physicians, hospitals, laboratory and ancillary facilities and let us not forget the most important player of all-the patient.

Respectfully submitted,

Louis Spikol M.D.