Testimony to Health IT Policy Committee: Clinical Documentation Hearing

Lipika Samal, MD, MPH February 13, 2013

Thank you for inviting me to speak at this meeting. My comments are based on my own experience as a primary care physician and researcher in Boston at Brigham and Women's Hospital, where I currently practice at the General Internal Medicine clinic affiliated with BWH. Previously I practiced in four primary care clinics in Baltimore, Maryland. I have also provided inpatient care at Johns Hopkins Bayview Medical Center and Johns Hopkins Hospital.

First, I want to reflect on the progress that has been made in recent years, remembering how I sat in a room like this one in August 2010 and listened to testimony on Stage 1 Meaningful Use requirements. Despite this progress, recent studies have shown that HIT continues to lag behind expectations for improvements in healthcare quality and reduced costs. As a result, much still needs to be done.

In this testimony, I will direct my comments toward care coordination from the perspective of a primary care provider (PCP). I will describe the referral process as a loop, in its simplest form: a PCP refers a patient to a specialist in order to answer a clinical question, the patient is evaluated by the specialist, the PCP receives recommendations, and the recommendations are acted upon, thereby closing the loop.

Two years ago I worked with a team of researchers and measure developers from Johns Hopkins and the National Committee on Quality Assurance. We conducted interviews with clinicians within integrated delivery systems that have adopted shared electronic health records (EHR). These interviews revealed that internal referrals did not involve a formal communication of the clinical question to be answered; instead providers were expected to read each others' notes. This is problematic. I can speak from my own experience and say that there is great variability in the process. I recently referred a patient to urology due to consistent hematuria (small amount of blood on a urine test). The specialist note included an assessment of the patient's longstanding incontinence, leaving me to wonder whether the specialist knew about the hematuria and did not think it worth mentioning or, more worrisome to me, the specialist did not recognize the presence of the hematuria. In this instance, I emailed the specialist and some amount of important clinical information was then siloed in my email account, however,—and this is critical—it was not recorded in the patient's medical record in the EHR.

Addressing referrals, we have two newly proposed functionalities for EHRs in the Stage 3 Meaningful Use Criteria. The first is electronic order entry for specialist referrals. This function could be an important tool if it were leveraged to promote the tracking of referrals as a guarantee that the loop is closed.

The second newly proposed functionality is for the specialist to acknowledge receipt of the referral and to send information back to the referring PCP. In addition to the clinical question to

be answered, pending studies and pertinent medication changes should be clear to both parties. Other patient-specific information should be communicated as well. Clinicians will embrace electronic referrals if they are designed in a way that does not require duplicate data entry, by which I mean documentation in clinical notes and in a separate template.

The third newly proposed functionality I would like to address is notifications to PCPs when patients are seen in the emergency department or admitted to the hospital. This past year I worked with David Bates, Patricia Dykes, a team of researchers from BWH, and the National Quality Forum to interview clinicians across the country about transitions to emergency departments, skilled nursing facilities, and home health agencies. We found that generally clinical information is still sent as packets of paper or faxes. An example of a gap I myself experienced was when a patient was transferred from a skilled nursing facility to an acute care hospital outside of my organization and then transferred back to the skilled nursing facility. The patient told me that she had been diagnosed with acute renal (kidney) failure at the hospital, but the problem was not mentioned in her discharge summary from the nursing facility. I suspect that the renal function improved before she traveled from the other hospital back to the nursing facility. If I had received a notification that she had been hospitalized I could have requested a discharge summary and, importantly, I could have had that information in front of me at her follow-up visit in my clinic. An open source secure communication platform, such as the Direct project, could be used to provide these notifications right now. Ideally, this messaging system will be incorporated into all EHRs.

In conclusion, new functionality to address care coordination with PCPs has high impact from a clinical standpoint. Electronic referrals to specialists will improve clinical outcomes, patient satisfaction, and clinician satisfaction. Notifications for hospitalizations and other significant events will promote care coordination across all healthcare settings, including skilled nursing facilities and home health agencies which are not incentivized to adopt EHRs under Meaningful Use. Including these entities is necessary to reduce rehospitalizations and costs. Thank you for your attention and I look forward to the question and answer session.