Request for Comment Submission – Reducing IT and Clinician Burden

My background includes 28+ years in IT and 22+ of those in Healthcare IT. My experience includes significant time building and deploying clinical and administrative systems in acute care setting, home care and for the past 2.5 year, outpatient services. For the past 1.5 years, the organization I work for has been searching for a new electronic health record/practice management system. As such, my knowledge of the market and relevant issues is current.

It would appear to me that the accompanying download “DRAFT Strategy” does a very nice job of summarizing the challenges for clinicians and administrators. And I would offer the following:

1. **Universal patient identifier**. The core issue at the heart of interoperability is patient identification. Agreeing to a standard here would jumpstart seamless interoperability versus burdensome interoperability that we have today.
2. **Standardizing Quality Measures**. At the very least develop a minimum core of these data points. We should be fine with extensions to a core set for specialties and other needs but from a regulatory perspective all quality data should be core data capture.
3. **Connecting this with what clinicians need to deliver patient care.** For typical physicals or sick visits, most medical providers want 1) lab results for the last year, 2) Diagnosis for the past year, 3) images/radiology results and 4) allergies. While much progress has been made to capture the world of clinical information, most of it is not relevant to a specific visit. The clinicians need to drive this and agree on standards – hopefully taking into account the quality measures.