Physician Insurer Magazine E-enhanced Content:

A Conversation with Jodi Daniel

Jodi Daniel, JD, MPH, a presenter at this year’s PIAA Medical Liability Conference, has served as Director in the Office of the National Coordinator for Health Information Technology (ONC), Department of Health and Human Services (HHS), since October 2005. In her current role as Director of the Office of Policy and Planning, she is responsible for considering and addressing the policy implications of key health information technology (HIT) activities. This includes establishing new policies and working with other Federal agencies and organizations and State governments to coordinate efforts and assure that existing and developing policies are consistent with health information exchange activities and nationwide goals. She leads ONC’s regulatory and legislative activities and manages ONC’s federal advisory committees, which provide advice on all HIT policy and standards related matters. She is also responsible for the development of ONC’s HIT strategic plan to shape the direction of Federal HIT activities. After her presentation, she spent a few moments with Physician Insurer editor Dana Murphy.

Murphy: What about the fact that Meaningful Use Stage 2 seems to be pretty difficult to achieve—and a lot of people are still struggling to achieve Stage 1?

Daniel: I am optimistic that the majority of providers will be able to achieve Meaningful Use. Also, CMS has just proposed a one-year extension of Stage 1, to give people extra time to come into compliance with it—and also to give the vendors of electronic health records [EHRs] software enough time to get the input they need. After that, they’ll have to implement any necessary changes, and then get folks trained in them.

We just had our Comment Period close. So we’re waiting to get input—since it’s only a proposed rule—and we’ll hear the comments from people about whether it’s too hard, too easy, or just right—and then we’ll make decisions about the final rule.

So it’s still in development. And our goal is to see that providers get to Stage 2 easily.

Murphy: And you think that any issues on interoperability can be resolved
in time meet your deadlines?

Daniel: Interoperability is a really important issue. We’ve seen improvements over time in interoperability. But developing standards and adopting them does take time. So it is an iterative process, which is why we’re going through these multiple stages of adoption and implementation. There are some interoperability requirements in Stage 1. There are increased standards and requirements in Stage 2.

We’re moving along a path toward greater interoperability and greater ability to exchange information over time. But with Stage 2, at least some of the key data elements that providers need should be in standardized form, so that this information can be shared.

So, it’s a process, and we are making good progress on it. We will continue to improve the standards, adopt new standards, and move toward greater interoperability over time.

Murphy: Does competition between vendors impede that process? Will their drive to say, “Mine is unique and better,” make it hard for a system to talk to a competitor’s EHR?

Daniel: We’re setting the standard. This is why the government needs to be involved. Every vendor will come up with his own proprietary ways of doing things. The government has a unique role in this space—to try and get consensus and come up with single standards for things, and then let vendors innovate on additional features and on better usability, and innovate by coming up with products that work best for different kinds of specialists—rather than on trying to innovate on the technical standards.

They can use what we develop as a platform, and then build on top of that with innovations, for products and capabilities beyond that.

Murphy: And there are models for this approach, too. The FCC has standards for high-definition television, for instance.

Daniel: Yes, exactly.

Murphy: But it is expensive to switch to EHRs. I’m wondering, how do you convince someone that investing in EHRs yields a good ROI?

Daniel: Honestly, I think the most important reason to adopt an EHR is because you want to improve patient care. Healthcare is incredibly complex, and providers need to have better information. There is more and more information about treatments, and diseases, with new research coming out all the time.

It takes time to embrace new technology. Some 100 years ago, there was tremendous resistance to
adopting the stethoscope. There were doctors who said that it would interfere with their relationship with their patients, by putting a physical device between them and the patient.

Now, it’s the standard of care, and nobody would consider practicing medicine without it. I believe EHRs will become essential technology, too—it’s just a matter of time. What we’re trying to do is just shorten that time for folks to adopt it. But it is something that is inevitable, because high-quality patient care demands it.

**Murphy: But can’t the burden of converting old paper records to EHRs be nearly overwhelming?**

Daniel: But there are very tangible benefits. There is one doctor’s office I went to—and ob/gyn, as I recall—where they were able to create two new exams rooms, after they’d gotten rid of all the paper records. They created a new clinical position, and increased the number of patients they saw, and increased revenue, just because they had more space to see more patients.

**Murphy: If you’re capturing the data electronically, aren’t you more likely to see what’s causing errors—because the data are in this format, instead of as provider’s notes?**

Daniel: Yes, I think EHRs will dramatically increase the knowledge about errors that are already occurring now, so that folks can have the data to see the emerging trends. They’ll be able to understand where some consistent challenges are occurring.

But also, the technology can help in reporting information on adverse outcomes, for example, to patient safety organizations, across a variety of different settings, to see if there are trends.

I think that the most powerful thing about the technology is that you can also build in solutions to clinical problems. You can actually come up with clinical decision support. You can change the way the EHR presents some information, to address the error that’s happening.

We see this with medical errors. Studies show that there are improvements in safety—if you know there are errors that happen when certain combinations of drugs are given, for instance, an alert pops up, to prevent that from happening. Or if a doctor is about to prescribe the wrong dosage, there can be an alert that pops up for that.

So EHRs can help in understanding the errors—you can’t fix something you don’t understand. They can help in reporting—a patient safety organization can investigate the errors. And they can help in building solutions into the system, to help prevent the errors in the first place.

**Murphy: Might it ever be the case the templates built into EHRs would lead a doctor down the wrong path? Before anyone knew AIDS was caused by a virus, how would a physician know to focus on infections? Doesn’t EHR technology need to keep current with the best new science?**

Daniel: Yes, I think that one of the challenges, particularly with clinical decision support, is keeping it up to date with medical knowledge. That said, the average time that elapses before a new technology is introduced into practice, from initial discovery, is 17 years.

So you can build new procedures into medical practice, in a more widespread way, by building it into technology that is adopted across a broad swath of medical practices.
Murphy: I’m thinking of the window when tissue plasminogen activator can be effective after a stroke. It was extended from three to four hours recently. So if most doctors knew about that, the EHR could impact treatment right at the bedside. True?

Daniel: Yes, exactly. And I think that we’re at the early stages of seeing the potential for EHRs and health information technology. Clinical decision support—the science behind that is still in its infancy.

The role of technology in engaging patients is just in its early phase. I think that the potential for that is huge. It can help patients become more engaged in their care—understanding it and becoming more participatory in it—because they have the technology to provide them with information, help them make decisions, and communicate with their doctors better.

The people in our office are highly motivated about EHRs. They believe they’re helping to improve health care outcomes, and change medicine for the better.