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Sharing is caring? Not for medical records

Problems plague system linking health providers

By PETER KORN
The Tribune

Recently, a naturopathic doctor at the National College of Natural Medicine in Southwest Portland sent a patient to a local hospital emergency department with what appeared to be a blood clot in her lung.

Later that day the naturopath — the primary care provider — wanted to make sure that her patient had been taken care of and the necessary CAT scan had been performed — and she wanted whatever had been done at the hospital to become part of the patient's permanent file.

The hospital and the naturopathic college both use the same electronic medical records system. And yet, according to Regina Dehen, chief medical officer at the naturopathic college, there was no way to electronically get the patient's records from the hospital to her primary care provider.

Last week, Dehen had a new patient referred to her by a local pain management physician who was quitting his practice. That doctor kept his patient's records electronically, but had a different system than the one in use at the naturopathic college and most of Portland's hospitals. The patient arrived at her appointment with Dehen carrying 300 pages of chart notes.

Dr. Regina Dehen of the National College of Natural Medicine works on her computer during a busy weekday morning.
TRIBUNE PHOTO: JONATHAN HOUSE

None of this was supposed to happen. Eight years ago, when hospitals and doctors were beginning to implement electronic recordkeeping, Portland health care leaders came together to ensure that all electronic patient records would be instantaneously available to all health care providers through a regionwide health information exchange.

The Health Data Exchange Group, formed by the Oregon Business Council, included representatives of hospitals, health insurers, physicians and patient advocates. They were hoping to develop a unifying record-sharing system before each institution installed and modified its own in-house system in ways that would make them incompatible with everyone else's. Ironically, according to experts, they may have been too early. Or, now it's too late.

"It's like the Ebola thing," says Dr. William Hersh, chairman of the Oregon Health & Science University department of medical informatics. Hersh is referring to the first U.S. Ebola victim, whose Dallas physicians apparently did not see a nurse's note in his electronic records saying he had been in Africa. "There's a lot of blame to go around."

Study after study has shown that seamless sharing of medical records between health care providers would keep patients healthier. Emergency doctors treating a patient at one hospital, for instance, could know what drugs an unconscious patient regularly takes, and thus avoid giving another medication that might cause a dangerous reaction.

There are additional reasons beyond better patient care to implement a record-sharing system. The exchange group

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estimated it would cost about $3.4 million a year to implement and run the system, but it could save an estimated $17 million a year locally. One of the reasons the exchange never got going is that the entities that would save most of that money (insurance companies) are not the same entities who would be paying most of the upfront costs (hospitals).

"There's no financial incentive for the providers," says Dr. Tom Yackel, an internist and OHSU's chief health informatics officer. "In fact, in many cases, the financial incentive is reversed. Better I don't know that the patient had an MRI a month ago and repeat it because in a fee-for-service world we get paid for the procedures we do, not the ones we avoid."

Today, almost all Portland-area hospitals use the same system, provided by Wisconsin-based Epic Corp. But many of the area's smaller physician practices use different systems. In fact, Denise Honzel, a health care consultant for the Oregon Business Council who was involved in the 2007 effort to form an exchange, says the expense of changing over to electronic records is forcing small physician practices to close or merge because they can't afford the change by themselves and federal Medicare policies are beginning to penalize practices that don't keep and share records electronically.

In Honzel's view, the first attempt at a regionwide data exchange was premature. "The technology was changing, and how did we know what we put in would be money well spent?" she says.

On the other hand, now that most hospitals and practices have electronic records systems, trying to make them all compatible might be harder than if compatibility had been established from the start, says Mark Savage, director of health IT policy and programs for the nonprofit National Partnership for Women & Families in Washington, D.C.

"There are a lot of complaints, 'Why are we investing in these systems and building these systems, and they're not talking well to each other?' It's a national issue," Savage says.

Locally, the situation on the ground has "hundreds of siloed solutions," says Mylia Christensen, executive director of nonprofit Oregon Health Care Quality Corp (Q Corp.). Oregon patients who switch health plans or see providers in different communities find their records often don't follow them.

"What we hear from consumers is they're shocked and surprised that the information isn't being shared between hospitals and providers," Christensen says. "They see it in all other industries, and they can't believe there are this many problems and barriers.'"

Christensen's organization has begun talking to Oregon health care leaders about another go at an information exchange. "Enough time has passed and enough investment has been made," she says. "Oregon has been pioneering in many ways, and this is another place we should come together."

Hersh says federal stimulus money during the recession prompted hospitals to switch to electronic recordkeeping as quickly as possible, even if that meant interconnectedness was sacrificed. And many health care players have been concerned about privacy issues. If it becomes too easy to transfer patient records among doctors and hospitals, it might become too easy for hackers to gain access to those same records. So decisions on record-sharing were put off.

Yackel says it will take financial incentives before hospitals and doctors fully embrace seamlessly sharing their patient records. Medicare officials are providing some of that, he says, by rewarding physicians and hospitals that meet national standards for information exchange. And progress, he says is being made.

Emergency department physicians across Portland, Yackel says, are now able to learn quickly if a patient they are seeing recently was seen in another of the city's emergency departments. In his own practice, Yackel says, he recently started to get notified when his primary care patients receive flu shots at a local Walgreens pharmacy, even though Walgreens doesn't use the same software as OHSU.

But the financial incentive for major record-sharing, according to Yackel, will have to come through the movement that he calls "accountable care." Medicaid patients in Oregon now are being handled by coordinated care organizations that allow providers to profit when overall medical costs are lowered. As more privately insured patients move away from fee for service coverage, the institutions that invest in record-sharing also will be realizing the cost savings, Yackel says.

Meanwhile, primary care provider Regina Dehen is continually reminded that despite the headaches of interconnectivity, having patient records stored electronically rather than on paper has improved her practice in many ways. Naturopathic doctors at the college now can press a few buttons and get a list of all males over age 50 who get care at the clinic and have not yet had a colonoscopy — and have a reminder sent that they need one.

But exchanging information with hospitals remains "like exploring a house with hundreds of rooms," Dehen says. That's because different departments at different hospitals tweak their software to suit their needs, making their data mostly indecipherable to anyone else.

"We're at that point with electronic medical records where I can get the information, but I may not be able to read it or parts of it may be uninterpretable by my system," Dehen says.

Sometimes Dehen gets a glimpse of the future. She says she was referred a new patient about a month ago and before seeing the patient Dehen found in her email inbox all the patient's charts and physician notes.

"Sometimes it works flawlessly, and it's amazing," Dehen says. "Unfortunately, right now, you go, 'Whew, it works,' as opposed to just taking it for granted."