

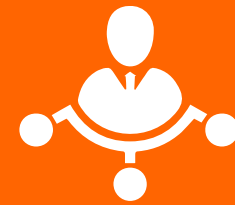
RAPID Roadmap Working Group Meeting

Planning the Future: Potential for EHR data abstraction



6-Nov-15

Personal Background



6-Nov-15



Clifford Cavanaugh



Co-Founded: 01/2010 M&A: 07/2015

EHR based - clinical quality data analysis, financial reporting, interfaces & conversions



Co-Founder & Chief Technology Officer

ONC certified, patient engagement platform, PHR & medical record exchange

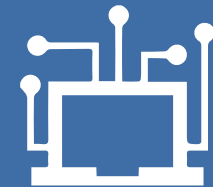
Working In:



For:



EHR presence on the RAPID roadmap



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Early in the project timeline

To determine if EHRs:

- a) Already contain a place for one or more of the elements in the core data set

OR

- b) The potential for such a place could be contained in future versions after the core data set is finalized.

Towards the end of the project timeline

- Determine method of interoperability between EHRs and registries.



SOONER – What should we be considering now?

- EHRs have a significant market penetration and data is available
 - ✧ Not solely based on interoperability standards, we just have a better understanding of the data models

- As a result
 - ✧ We can investigate real EHR repositories for available clinical data points
 - ✧ Which will assist in determining
 - a) What data is available now
 - b) What gaps need to be filled
 - c) What we can expect from adding additional fields



LATER – What should we do when we have a complete dataset?

- Achieving Widespread Adoption
 - ✧ ONC → Certified EHR Products → Presence in the provider's EHR
 - ✧ CMS → Financial Incentives (e.g. CQM / MU) → Adoption in clinical workflow

- Understanding Interoperability
 - ✧ EHRs will be required to offer developer APIs to access data
 - ✧ Relevant data may be contained in C-CDA documents
 - ✧ The conduit for connectivity between EHRs, registries, and HIEs (to name a few) will be dependent on the ability utilize old and new protocols
 - ✓ HL7, C-CDA, Direct, Direct DB Queries, FHIR, Developer APIs

Considerations



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Correlation & Causation: difficult to assess for some specialties, esp. Cardiology

- SOAP note assessments frequently relate to the patient, NOT the specific procedure / diagnosis, and consequently EHR data aggregates can be **misleading**
 - ✧ Example: If a patient has a number of chronic illnesses being treated by the rendering cardiologist, an assessment of “improving” or “worsening” will likely not have a relationship to a single diagnosis or procedure.



- EHR data aggregates are **clinically beneficial** when the nature of an outcome is observed by an identified value
 - ✧ Example: Of all patients with ACME's LVAD implant, that had an an EF value of 30% prior to the surgical encounter...
 - ✧ We can determine the number of patients that now have a normal EF value in the post-op encounter

If EHR data will be used to measure outcomes, a relationship between the device and the element contained in Core Data Set will first need to be determined.



And of course, the most obvious:

- Most EHR data is entered by clinicians with busy schedules.
- Without incentive to enter the data discretely, there will likely be no usable data

Questions?

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