TERMINOLOGY RECOMMENDATIONS

We are currently using a basic EMR system which is nothing more than a repository for patient data offering no true benefit in the improvement of patient care. My recommendation is that we switch to the Allscripts® Professional EHR system, a CCHIT certified EHR system which already has the built in healthcare standard terminologies that will help our providers achieve meeting the meaningful use requirements mandated by the government. With it's built in healthcare standard terminologies, the implementation of the Allscripts® Professional EHR system, will allow for improvement in the quality of patient care.

Below I've highlighted some of the areas where improvement will be made with the implementation of Allscripts® Professional EHR and the standard healthcare terminologies that it offers:

Laboratory Orders and Results

- Current Status – Our current EMR system does not allow for inbound and outbound laboratory orders and results. Today laboratory orders are entered into the EHR system and then the laboratory manifest must be printed and faxed or sent by courier to the laboratory for result processing. Once the laboratory results are complete, they are faxed to our office where our staff will pull the patient's chart, attach it, and get it ready for the provider's review and signature. Many times lab results don't come back in, or the patient never showed for their lab work or the results are misfiled into the wrong patient's chart.
- Benefits (who and how) – Allscripts® Professional EHR uses the LOINC (Logical Observation Identifiers Names and Codes) standard terminologies database which facilitates the exchange of bidirectional orders and results through an HL7 interface between the practice and the reference laboratory. The implementation of LOINC will eliminate the need for faxing, printing or filing labs and results due to the automatic inbound/outbound functionality.
- Challenges – There will be a few challenges in ensuring that providers must be constantly aware of checking for lab results in their electronic inbox for review and signing.

Medication Prescription Writing

- Current Status – Our current EMR system doesn't contain a standardized drug database for drug to drug, drug to allergy interaction checking or electronic prescription writing, Today our providers are hand writing prescriptions because our EMR system does not have a standardized medication drug database that can speak to other EMR systems or pharmacies. This is a very time consuming process for writing new prescriptions as well as refills with the inability to receive real-time alerts for any drug interactions. There is an increase of medication errors due to misunderstood handwritten prescriptions by pharmacists, which could potentially be fatal to our patient population.
- Benefits – Allscripts® Professional EHR has the built-in RXNorm nomenclature which is used in conjunction with the MediSpan medication database for writing electronic medication prescriptions to pharmacies and for drug interaction checking. The RXNorm drug vocabularies are commonly used in pharmacy management and drug interaction software[i] , like MediSpan. With the implementation of the RXNorm standard terminology it will aid in the reduction of prescription writing errors, eliminate the need for handwriting prescriptions and improve patient safety.
- Challenges – As it stands today, not all pharmacies (small community pharmacies) are accepting ePrescribed prescriptions. However, this will still allow the provider to use the medication

database (which contains the RXNorm standards) to document the prescription written to the patient and print the prescription versus electronically prescribing it.

Procedure Code Search

- Current Status – Our current EHR system is cumbersome when having to search for a procedure code (office codes, codes for services, pathology codes, etc.). Many times the provider cannot find the code they are looking for and may select an incorrect code for billing. This leads to erroneous claims being sent out thus holding up reimbursements for our practice.
- Benefits (who and how?) – Allscripts® Professional EHR has integrated the IMO Procedure IT lookup functionality which allows a provider and staff to easily search for any procedure code with little effort. The IMO Procedure IT program uses the AMA's CPT® codes as well as SNOMED CT®. The functionality of IMO Procedure IT gives the providers only one place to search for either procedure code vocabulary.
- Challenges - There are no challenges known at the present time.

Reporting Capabilities

- Current Status – Our current EHR system does not offer the capability for easy reporting and the aggregation of data for analytical purposes. Providers must rely on their memory and sifting through patients charts to find information needed for enhancing the quality of patient care. For example: there isn't a way to pull a report of all our Diabetic patients who are overdue for their A1C labs. Or if a provider wanted a report of all his Diabetic patients on certain medications today, the work involved in collecting this data is unimaginable.
- Benefits (who and how?) – Allscripts® Professional EHR uses healthcare standard terminologies such as the AMA CPT® coding system, SNOMED CT®, ICD9, ICD10 and RXNorm nomenclature for medications which allow for capturing clinical data for reporting purposes. As providers electronically document in the patient's chart, the clinical data, from the categories listed above, can be pulled easily into a report based on the needs of the practice and the provider. The report examples previously mentioned above are prebuilt into the Allscripts® Professional EHR system through the use of the integrated healthcare standard terminologies mentioned. In addition, providers can readily participate in the Physician Quality Reporting System (PQRS) measure.
- Challenges – There are some challenges in that adequate training must be provided so as to avoid selecting improper codes when documenting in patient's record and thus generating inaccurate reporting

Clinical Decision Support (CDS)

- Current Status – Our current EHR system offers no clinical alerts for managing chronic medical conditions (i.e., Diabetes, CHF) or for handling standard preventive maintenance medicine (i.e. yearly Mammograms due, Colonoscopy due, etc.). This poses a challenge for providers and staff to remember or sift through patient charts to determine when the next labs are needed or if a yearly Mammogram was done on a patient.
- Benefits (who and how?) - Allscripts® Professional EHR has an embedded clinical decision support tool (Diagnosis One) which uses the HEDIS guidelines for evidence based medicine. Based on the standard terminologies from Diagnosis One and the HEDIS guidelines, it provides real-time alerts for providers based on the needs of a patient. For example: If a patient is a Diabetic, the clinical decision support tool will generate an alert immediately indicating whether the patient needs a foot exam, eye exam, lab work for A1C, etc. This is yet another tool that contains the standard terminology necessary to improve patient care.

- Challenges – Alert fatigue may cause providers to overlook significant clinical alerts for needed lab order testing, imaging, etc. and therefore may lead to missed items necessary for disease management.

I believe it is imperative that our practice make the switch from our current EMR system to the Allscripts® Professional EHR system which will allow our practice to continue providing excellent patient care while also enhancing our clinical workflows through the use of healthcare standard terminologies.

[i] http://clinfowiki.org/wiki/index.php/RxNorm