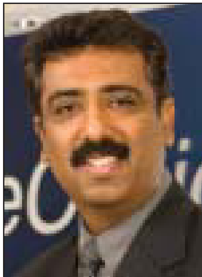
Box Store's EHR System Targets Small Practices

BY JOYCE FRIEDEN

The big box store Sam's Club, which is owned by Wal-Mart, is setting its sights on the information technology frontier: The stores are starting to market electronic health record systems aimed at medical practices with one to three physicians.



Not everyone, though, is buying the ability of such off-the-shelf systems to be used in a meaningful way in clinical practice. And with EHR systems being held up as essential to health care reform and the ability to get a grip on unnecessary spending, a lot is riding on these products.

With the package offered by Sam's Club, practices will receive three laptops and a tablet notebook from Dell, a laser printer, and EHR and practice management software from eClinicalWorks. The package also includes 12 weeks of on-site setup, customization, and support. The package costs less than $25,000 for the first physician and up to $10,000 for each additional physician in the practice. The package, which is available for purchase online, is currently being sold only to physicians in Georgia, Illinois, and Virginia, with a nationwide rollout planned for later this year.

"We have 200,000 medical-type [business members] at our 600 clubs nationwide," explained Susan Koehler, senior manager in corporate communications at the Sam's Club home office in Bentonville, Ark. Wal-Mart had amassed some experience using Dell and eClinical Works EHR systems at its walk-in medical RediClinics and it worked well, so the idea was born to start marketing it to Sam's Club members.

Although the package is aggressively priced, it is designed to be customized.

MR. NAVANI

The company chose Sam's Club rather than Wal-Mart to distribute the EHR because, unlike Wal-Mart, Sam's Club has a one-on-one relationship with the local businesses that buy their supplies at the club, "so we have relationships at the local level with those doctors," Ms. Koehler said.

Georgia, Illinois, and Virginia were selected for the rollout because "they were a good representation of broad-band access with a mix of rural and small-town community doctors," she said. At the same time, those states include big cities such as Atlanta and Chicago. Ms. Koehler would not say how many systems have been sold since the product was launched in early April, but "we're very pleased with the interest" it has gotten, she said.

Discounted hardware from Dell and some money saved on "interfaces coming out of the box" allowed Sam's Club to price its EHR system aggressively, explained Girish Navani, cofounder and CEO of eClinicalWorks in Westborough, Mass.

Yet the package does not offer any less customization than if a physician practice was to buy a system individually, Mr. Navani said.

Dr. Steven Waldren, director of the Center for Health Information Technology at the American Academy of Family Physicians (AAFP), said that packages like Sam's Club's have advantages and disadvantages. Although the product is off the shelf, "it's really a product and service package, not [just] a box of software that you order and then get installed," he noted, yet the disadvantage is that it is prepackaged, "so decisions are made for you when they put it together."

Two factors are key in EHR selection: content and workflow, Dr. Waldren said. An EHR system may have plenty of content, but "does it have the templates you need and want?" If you have midlevel personnel, "how does the signoff process work?" Does the nursing staff put in a review of the present illness "and then you verify that? If [the workflow] doesn't work for you, what type of customization is possible?"

'There are probably going to be disadvantages around customization' and flexibility.

DR. WALDREN

By prepackaging elements together, off-the-shelf systems will be less expensive, "but there are probably going to be disadvantages around customization and the flexibility practices are going to have," he said. ■

HHS Getting Closer to Defining EHR's 'Meaningful Use'

BY JOYCE FRIEDEN

WASHINGTON — Requirements for making "meaningful use" of an electronic health records system can't be too onerous, or physicians will be discouraged from buying and using an EHR, Dr. Neil Calman said at a health information technology meeting convened by the Department of Health and Human Services.

Under the Recovery Act, formally known as the American Recovery and Reinvestment Act, $19 billion in stimulus money has been set aside to encourage adoption of health information technology, including electronic health records (EHRs). The money includes $44,000 in financial incentives for each physician who purchases a certified EHR system and makes "meaningful use" of it by 2011; physicians who adopt EHRs later will also get an incentive, but the amount will diminish gradually over several years and disappear completely after 2014. Providers who have not adopted EHRs by 2015 will see reductions in their Medicare reimbursement.

To put the law into effect, the government has to define "meaningful use." A health information technology (HIT) Policy Committee will make recommendations for the definition; the actual regulations will be written by staff members at the Centers for Medicare and Medicaid Services (CMS).

At a recent meeting, HIT Policy Committee member Anthony Trenkle, director of the CMS Office of E-Health Standards and Services, said that the agency plans to issue draft regulations at the end of the year, with 60 days for a comment period. The final regulations are slated to be issued early next year.

The committee heard a preliminary report from the meaningful use subgroup, which outlined its suggestions for meaningful use requirements in 2011, 2013, and 2015 (see box). Committee members expressed varying opinions on whether the requirements were too few or too many.

"This is a very aggressive model," said Gayle Harrell, a former Florida state legislator. She described her recent visit to a Florida health system where administrators estimated it would take 3 years to install a computerized order entry system in its 35 clinics. "My great concern is that this is going to be difficult to achieve."

But Dr. Calman, who also serves on the committee, disagreed. "I don't think we should base our policy on what one organization is doing," he said. Dr. Calman is president and CEO of the Institute for Family Health, Bronx, New York. "We have lots of models [that have worked more efficiently] and we should focus on that."

David Lansky, Ph.D., of the Pacific Business Group on Health, said he would favor accelerating implementation of a small number of items, such as clinical decision support, from 2013 to 2011. "For 2013, we would [show that we have] a full slate of stringent requirements, so people know what's coming," he said. For example, physicians who don't purchase a system until 2014 would have to make sure their system met the meaningful use requirements for both 2011 and 2013.

The committee needs to be aware of how such changes would affect providers who adopt EHRs in later years, according to Dr. Calman.

"We're creating another incentive for people to adopt early," he said. Not only do the incentives get smaller and smaller, but the bar gets higher and higher over time. "If that's what we want to do, that's OK, but we ought to be conscious of that."

In reality there are two timelines: The first is based on what we'd like our delivery system to be able to do and the second is based on what somebody may be able to achieve in the first year or the second year, he said. ■

Proposed Definition Requirements by Year

In 2011:
► **Capturing and sharing data.** This encompasses maintaining a current problem list, maintaining an active medication list, recording vital signs, and incorporating test results into the EHR.
► **Using computerized physician order entry (CPOE) for all types of orders.** This includes electronic prescribing and similar functions, such as drug allergy and formulary checks.
► **Managing patient populations.** This begins with generating lists of patients sorted by condition and sending patient reminders as needed.

In 2013:
► **Improving quality, safety, and efficiency.** This involves using evidence-based order sets, implementing clinical decision support at the point of care, and reporting information to an external disease registry.
► **Engaging patients and families.** This includes offering patient-provider electronic messaging, documenting family medical history, and uploading data from home monitoring devices.
► **Ensuring privacy and protecting security.** This involves using de-identified data when reporting population-wide health information.

In 2015:
► **Improving population and public health.** This includes using data derived from EHRs, automating real-time patient surveillance, and generating ad hoc quality reports.
► **Coordinating care.** Accessing comprehensive patient data from available sources.
► **Continue to engage patients and families.** This is expanded to include providing access to a personal health record with data from the EHR, providing patients with self-management tools, and receiving electronic data on patients' experience of care.

Source: June 2009 HIT Policy Committee