THE OFFICE

Small Practices Selecting EHR

When Dr. Maggie Blackburn decided to move in 2000 from a hospital clinic to a new solo practice in Stanford, a rural upstate New York town, she had a strong adversity to lining the walls of her already cramped office with paper charts. After test-driving several systems, she spent an estimated $23,000 on software and hardware, and her practice was up and running with a staff of two (a nurse and a front desk assistant). Although the options in electronic medical record systems are a lot different today than they were 7 years ago, Dr. Blackburn's advice still is sage straight talk from a family physician who didn't know what a network server was when she started. In this month's column, she shares her insights about the choices and compromises she made in making an EHR system work for her.

BY MAGGIE BLACKBURN, M.D.

If you're in a small or solo practice and you're looking for an electronic health record system, congratulations. Although you may not have much capital, there are fewer people to please, which makes defining your priorities a lot easier. That said, anyone looking to invest in an EHR system should know two things: First, don't expect the system to run smoothly all the time—it will break down and there will be glitches. And second, it won't pay for itself.

Like buying a house, the financial outlay is ongoing (service contracts for tech support cost me $4,000-$5,000 annually and then there are hardware upgrades). But the investment will pay for itself in terms of enhancing your quality of life. The time you save by not having to do repetitive tasks and the workflow enhancements are priceless, especially to someone who would rather head home at the end of the day than be chained to an office desk finishing chart notes.

There are conveniences that feel like windfalls: When Vioxx was taken off the market in 2004, we had a letter written and addressed to all of our patients who were taking the cyclooxygenase-2 within 15 minutes to advise them about the matter.

And then there is the undeniable ease with which one can participate in clinical trials. Identifying all diabetes patients and tracking HbA_{1c} levels, or any other quality measure, is almost effortless.

However, selecting the most appropriate system for your practice takes thoughtful research. Prioritize your wish list and then realize that it's likely to change. When I set out to purchase a system, options such as messaging and customizable fields didn't seem very important, but in retrospect, they have made a huge difference. The messaging component has enhanced interoffice communication in unanticipated ways, and having customizable fields has helped make the system interface feel comfortable.

Most physicians want their system to work smoothly right out of the box. But that's not realistic. A common complaint among physicians with new systems is that entering patient information takes more time with EHR than it does with a paper chart. Being able to customize templates myself—and change data entry options as I used the system—has made it much easier to iron out kinks.

The system I ended up with allowed me to finish my chart notes by the time the patient left the exam room and to have a script on the front desk awaiting my signature. My goal was to not have patient charts to catch up on at the end of the day, and having a system I could easily customize myself made that goal attainable.

Another component, having lab interface, has been a tremendous bonus. It eliminates the errors that occur when lab results need to be transcribed by hand. All lab results are downloaded from the lab directly into patient charts, and abnormal values are flagged for my review. A lab requisition component, which I added later, makes it infinitely easier to track what has been ordered and whether results are back.

When I started, I wanted the princess tech support plan, the one that allows the person who knows virtually nothing about computers to call and whine. It costs significantly more, but it's been well worth it. Tech support is an area you definitely do not want to skimp on, and good plans will require a hefty annual fee. Just make sure you check out the company claims regarding tech support by speaking with current users of the system.

Before you buy anything, shop around. Test products yourself. Sales representatives will be able to move around the system a lot faster than you can. Be explicit about needing to be able to use the system yourself. Review the templates; ask yourself if you can live with them as they are and whether the interface meets your needs. How easily can you add components later? Consider visiting a comparable medical office site that uses the software you are planning to buy.

And know the vendors. What is their track record? Many physicians have been burned selecting an EHR because they invested in systems that were sold to them by vendors who are no longer in business, and they end up with no tech support.

The system I bought cost more than I initially wanted to spend. I wanted to do it for pennies, but I finally realized that if was going to do this, it was worth it to spend more money and get more of the things that I wanted. Dollars can be shaved off software licencing and tech support fees by being realistic about the number of workstations you need at any one time for scheduling access vs patient chart access.

After you have a system in place, have a backup plan for when the system breaks down. My system never went down for more than a few hours. I never lost data, but I have heard horror stories from colleagues that did. So good luck. This leap of faith will pay off in unexpected ways. Just be sure to back up your data religiously. ■

DR. BLACKBURN *is now an assistant professor in the Department of Family Medicine and Rural Health at Florida State University, Tallahassee. The system she purchased was from Practice Partner. She has no financial relationship with any EHR companies.*

Stakeholder Collaboratives to Focus on Health Care 'Value'

BY DENISE NAPOLI
Assistant Editor

WASHINGTON — The Bush administration aims to move forward on its goal of health care price and quality transparency through its new Value-Driven Health Care Initiative.

The initiative, which will certify and support regional collaboratives of health care payers, providers, and purchasers, was announced by Health and Human Services Secretary Michael Leavitt at a press briefing sponsored by the journal Health Affairs.

Participants in the program's collaborative groups, called Value Exchanges, will be able to share practices for increasing quality with fellow members through a federally funded learning network, for which $4 million has been earmarked in the proposed 2008 federal budget. Providers who can demonstrate improved transparency and quality are also likely to reap rewards from payers.

Mr. Leavitt gave as an example one private insurer affiliated with a pilot Value Exchange in California that paid out as much as $50 million to physicians who'd met certain standards of quality care.

"[Insurers] rewarded the quality practice. But if you don't have a standard way of measuring [quality], then those [bonuses] are not able to be developed or executed," he said.

Dr. John Tooker, executive vice president and chief executive officer of the American College of Physicians (ACP), said that it is too soon to determine the success of the pilot programs.

"I think the [level of physician] engagement in the program will determine how much value is to be derived from the program," he said. However, "You've got to start somewhere. The ACP and many other medical societies have been supportive of moving the evidence-based performance measures into meaningful field testing. … These Value Exchanges provide an opportunity to test these measures."

In 5 years, the word 'value' will be a regular part of the medical lexicon. 'Ten years from now, this network will have matured into a national network.'

Quality standards by which care will be measured are being formulated by physician groups.

"The standards are being established by the medical family," said Mr. Leavitt.

Leadership from groups such as the American Academy of Family Physicians, the ACP, and the Society for Thoracic Surgery, as well as the American Medical Association's Physician Consortium for Performance Improvement, will provide the basis, said Dr. Carolyn Clancy, director of the Agency for Healthcare Research and Quality. "This is what the profession believes is the best science," said Dr. Clancy at the meeting.

Though the program will use national measures of quality, it will be governed locally.

Local control is important for two reasons, Mr. Leavitt said. The first deals with the initial collection of medical records with which the program would develop comparisons between providers. "Until we have a robust system of electronic health records, the [process of acquiring] this information is essentially going in and looking at medical records—most of the time, paper records—to determine what quality is and when it occurs. That, by its very nature, is local." The second reason why local facilitation is important has to do with trust, he said. "This is a very significant change and it requires people to work together collaboratively in order to be comfortable. [Doctors] will be much less likely to work with Washington, where they can't affect the process, [rather than local networks]."

To become a Value Exchange, a collaborative must submit an application to HHS detailing its adherence to four "cornerstones" of the program. In addition to the adoption of an electronic medical records system, these include public reporting of performance; public reporting of price; and the support of incentives rewarding quality and value.

Mr. Leavitt sketched a rough timeline for widespread adoption of the program.

"Five years from now, the word 'value' will be a regular part of the medical lexicon," he said. "Ten years from now, this network will have matured into a national network." He added that in order for this widespread collection and pooling of data to occur, "electronic medical records, as you can see, have to be the backbone of this system." ■