Assess Needs, Readiness Before Selecting an EHR

AMIA offers recommendations on selecting and implementing an electronic health record system.

BY MARY ELLEN SCHNEIDER
Senior Writer

BOSTON — Choosing an electronic health record for your practice involves a comprehensive readiness and needs assessment, according to participants in a congress sponsored by the American Medical Informatics Association.

A group of about 100 physicians, nurse "informaticians," clinical informaticians, pharmacists, consultants, and others met during AMIA's spring congress to brainstorm ideas about how best to select an EHR. Participants in the work group, who had a range of experience with EHRs, contributed their advice, which was then condensed into a short presentation given at the close of the AMIA meeting.

Here are some of the recommendations from the AMIA work group:

Readiness Assessment

► Develop an information strategy. The first step is to figure out the organization's information strategy by determining goals, the information needed to achieve those goals, and how the information needs to be accessed.

"If you don't have an information strategy, first and foremost, you're really not ready," said Eric Rose, M.D., a physician consultant for IDX Systems in Seattle, who presented the recommendations from the AMIA workshop on selecting an EHR.

► Develop an education strategy. Once an information strategy is in place, the practice needs an education strategy for getting everyone up to speed on the EHR product selection process.

► Let everyone in the organization know this is a business transformation process, not an IT project.

► Don't try to nail down costs too precisely. While it's important to have a budget, practices also need to recognize that some of the costs will be unpredictable, the group advised.

► Determine the capabilities, willingness, and expectations of everyone in the practice.

Needs Assessment

Next, practices should assess their needs in terms of features and functions, the work group concluded.

► Focus on "pain points" to uncover functional requirements. "Don't ask people what you want the EHR to do for you, ask people where does it hurt," Dr. Rose said.

► Figure out the organization-wide goals and objectives to determine EHR needs.

► Assess your in-house IT expertise to determine desirable features. If the practice employs a skilled database analyst, it may not need an EHR with built-in reporting functionality, Dr. Rose said.

► Use available resources on successful needs assessment processes. For example, the Healthcare Information and Management Systems Society has an EHR selector at www.ehrselector.com.

How to Write an RFP

Once the practice has taken stock of its needs, they can begin to write a request for proposals (RFP).

► Keep it simple. "The more complex your RFP is, the more complex the responses will be," Dr. Rose said.

► Address all aspects of the practice's relationship with the vendor in the RFP. An RFP should ask: What training options are available? How much will training cost? How do software upgrades work? How will the vendor work with third-party vendors?

► Ask vendors to differentiate themselves from the competition. The RFP is one way to get vendors to tell you what they can offer that is different or better than other companies.

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► Involve all clinical disciplines in RFP development.

► Establish a straightforward, replicable assessment process before sending out the RFP. Practices should be able to redo the RFP in case the procurement process is derailed or one of the key staff members leaves the practice.

Site Visits and Demos

When a practice has narrowed down its choice of vendors, the physicians and administrators may want to begin demonstrations and site visits to test the products.

► Consider site visit locations other than those suggested by the vendor. The AMIA group recommended doing your own research to find out who is using a vendor's software. Don't just call the references on a vendor's list, seek out independent sources, the work group reported.

► Call ahead when conducting site visits. Practices should try to make the most of the visit by calling ahead and making sure they are visiting a similar organization. The site visit team should collect contact information to bring back for those staff members who couldn't attend the site visit but may want to ask follow-up questions over the phone.

► In scripted demonstrations, hold back some portion to be revealed at the time of the demo. The AMIA group suggested that practices ask a few unplanned questions to get around some the lack of transparency in a the scripted process.

► Make scoring simple and explicit. ∎

Certification of EHRs to Begin This Month

BY MARY ELLEN SCHNEIDER
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BOSTON — A coalition of private sector informatics groups plans to launch a process for certifying electronic health record products late this year.

Certification will bring some predictability into the market for physicians, vendors, and payers, Mark Leavitt, M.D., chair of the Certification Commission for Healthcare Information Technology, said at a congress sponsored by the American Medical Informatics Association.

The commission's initial scope is to certify electronic health record (EHR) products for physician offices and other ambulatory settings. They plan to begin beta testing products as part of a pilot project this month.

By the end of the year, the commission is slated to publish certification requirements and to outline a roadmap for vendors for requirements for the next 1-2 years, Dr. Leavitt said.

The roadmap is a key part of the commission's work because the cycle for getting new features, interfaces, and interoperability functions into a product can be 6-18 months or more. "We need to signal to the industry as to where we are going next, so it has time to respond," he said.

The commission was founded last year by the American Health Information Management Association, the Healthcare Information and Management Systems Society (HIMSS), and the National Alliance for Health Information Technology.

The three groups have provided seed funding and have loaned staff members to the effort. As the process moves forward, the commission will charge fees to the vendors to cover the cost of testing the products.

They also plan to seek sustaining grants from other organizations to maintain their operations, said Dr. Leav-

itt, who is also the medical director at HIMSS.

Under the voluntary certification process, products will either be certified or not certified. "We are not trying to create a competitive rating system," Dr. Leavitt said.

The idea is that the commission will be setting a baseline standard, leaving space for competition and innovation above that standard. And the standard needs to be based on reality, he said, to get participation from vendors.

In the first year of certification, the members of the commission want to be sure that they don't create requirements that will shut down the marketplace. However, Dr. Leavitt said he expects that as the standards become more rigorous in the years to come, the marketplace will evolve to follow the certification process.

Currently, adoption is progressing slowly because the market lacks order and predictability. For example, physicians won't buy EHR systems until costs are lower, their own risk is lower, and the incentives are higher. However, it's hard for vendors to bring down prices when the sales volumes are so low and the sales cycle is so costly.

Payers have expressed interest in offering incentives for the use of EHRs, but many are concerned that if they start to offer incentives, an industry of minimal systems will spring up to capture that money, Dr. Leavitt said.

Certification is a way to take some of the risk out of the process for all the players, Dr. Leavitt said.

Another challenge is to make sure that there isn't a wave of adoption of products that aren't interoperable.

"We want to ensure that these products that get adopted will be interoperable in this emerging infrastructure," according to Dr. Leavitt. "The challenge is the infrastructure isn't there yet, it's emerging." ∎

For more information on the certification timeline, visit www.cchit.org.

Reasons Why Your Patients Don't Comply

PHILADELPHIA — Noncompliance with physicians' orders "is a real problem" that costs the United States $100 billion annually and results in at least 125,000 deaths, said Reid Oetjen, director of graduate health services administration studies at the University of Central Florida.

At the annual conference of the Medical Group Management association, Dr. Oetjen said that there are three types of noncompliers:

► Unwitting noncompliers, who misunderstand their prescribed regimen or don't receive adequate information about the regimen. Language barriers and use of medical jargon may complicate matters. Sometimes, patients who receive bad news may not be able to process information presented to them.

► Unwilling noncompliers, who don't follow treatment orders because of economic, physical, or personal barriers—for example, a patient who can't afford a certain drug.

► Then there are the intelligent noncompliers, who make an intentional choice to alter their therapy without consulting their physician.

Physicians often overestimate the degree of correspondence between their orders and patient behavior, Mr. Oetjen said.

Compliance is problematic even with chronic or life-threatening conditions. A 2001 study of HIV protease inhibitor cocktails revealed that fewer than 50% of the patients took their antiretroviral medication correctly and on time. A too complex regimen was the source of the noncompliance among these patients.

—*Jennifer Silverman*