

VA Moves Forward with Patient Access to EMRs

Department of Veterans Affairs is ramping up a pilot project intended to go national this spring.

BY MARY ELLEN SCHNEIDER
Senior Writer

Physicians at the Department of Veterans Affairs have been using an electronic medical record for about 20 years, so officials there are getting ready to take the next step—online patient access to their medical records.

Next May, the VA plans to provide patients with online access to their medical information through an existing patient portal called My HealtheVet—www.myhealth.va.gov.

Currently, the project is in a pilot phase at nine VA medical centers around the country. As part of the pilot, patients are able to log in and see features of their medical record including hospital admissions, allergies, prescriptions, a problem list, progress notes, discharge summaries, vital signs, lab reports, radiology reports, and ECG reports.

“It really represents a fundamental advancement,” said Dr. Robert Kolodner chief health informatics officer at the Veterans Health Administration.

VA officials are now working on the details to allow nationwide patient access to medical records. Though a small number of institutions and physicians offer some type of patient portal access, it’s still not the norm, Dr. Kolodner said.

But this may be about to change, according to Dr. Steven E. Waldren assistant director of the Center for Health Information Technology at the American Academy of Family Physicians.

More widespread adoption of patient

portals and personal health records may be driven by the emergence of health savings accounts, which put more decision making in the hands of patients. In addition, the development of the Continuity of Care Record—a standard that allows personal health summary information in an electronic file to be transferred in multiple formats—is likely to aid the development of these products, Dr. Waldren said.

When the VA project is expanded nationally, there will be some small changes from the pilot. For example, patients won’t have access to their progress notes, at least not at first, Dr. Kolodner said. The release of progress notes will happen in a later phase of the rollout, he said. But once they are added, physicians will be able to use the notes as a tool for patient education by adding instructions that patients can later read at home.

Officials are also working out the appropriate time lag between when lab results are available to the physician and when they are released to the patient’s online record. The idea is to give the clinician time to notify the patient of a lab result so patients aren’t seeing that information for the first time online, he said.

The VA has yet to perform a formal evaluation of the pilot, said My HealtheVet program director Ginger Price. But questionnaires completed by patients participating in the pilot indicate that there is widespread support for expanding the program nationally. And anecdotal reports show that the online record has made it easier for patients to

share information with their caregivers, she said.

But online access won’t be entirely new for VA patients. For the past 2 years, patients across the VA system have been able to access the online patient portal My HealtheVet to self-enter both personal and medical information.

The Web site allows veterans to enter personal data such as their contact information, emergency telephone numbers, health care providers, treatment locations, and health insurance.

VA patients can also enter their prescription information and view their prescription and refill history. And they can order refills online through the site.

In addition to prescriptions, they can enter medical information such as over-the-counter drugs and herbal supplements that they take. They can also record their allergies, tests, medical events, and immunizations.

For example, the medical event section allows patients to enter the type of events, the start date and stop date, and the response from their physician.

The site also includes a Health eLog feature where patients can enter their blood pressure, blood sugar level, cholesterol level, body temperature, weight, heart rate, and pain level.

For pain information, patients enter data that includes the time and their pain level on a scale from 0 to 10. And patients can enter additional comments on their pain.

VA patients can also record their mili-

tary health history on the site.

The idea is that patients will use the site to help them better manage their health, get patient education information, or print out their self-entered information and bring it in to their physician, Dr. Kolodner said. But the self-entered information is entirely controlled by the patient. VA physicians do not have access to the site, and it’s up to patients whether they want

to share the information with health care providers or caregivers.

On Veterans Day, the portal will be expanded to include food and activity journals. In addition, patients can begin adding pulse oximetry results to the Health eLog.

When the pilot is completed this spring, patients

will be able to access their medical record in the same place as their self-entered data. But the patients will retain control of the self-entered information, Dr. Kolodner said. At that point, patients can choose whether to allow their physician electronic access to the self-entered information.

In the future, patients will also have the opportunity to integrate their self-entered information into their VA medical record. “The decision to share the information is the patient’s,” Dr. Kolodner said.

VA officials are also considering secure online messaging as a possible future improvement to the patient portal. The feedback from physicians has been that they would like to have messaging so that they can communicate online with patients, Ms. Price said. ■

Physicians will be able to use the notes as a tool for patient education by adding instructions that patients can later read at home.

Hospital Studies: Volume May Not Equal Quality

BY TIMOTHY F. KIRN
Sacramento Bureau

SAN FRANCISCO — The generalization that the more procedures a hospital does, the better it is, may be an oversimplification at best and misleading at worst, according to two studies presented at the annual clinical congress of the American College of Surgeons.

In one study, Dr. Melissa A. Meyers and associates compared colectomy mortality in rural and urban hospitals using Medicare data on 279,385 patients who had surgery between 1994 and 1999.

Overall mortality was the same in the two groups. In small rural hospitals with a low volume of procedures, mortality was 6.7%. In urban hospitals, most of which had higher volume, the rate was 6.4%, said Dr. Meyers of the surgery department at Dartmouth-Hitchcock Medical Center, Lebanon, N.H.

Analysis of the data did show some evidence that the more colectomies a hospital performed the lower the mortality, but that observation held only for the urban hospitals. Rural hospitals had no such correlation between volume and mortality,

though 90% of the rural hospitals had a low volume. Moreover, the mortality at the rural hospitals was not much different from that at the best urban hospitals, where the rate was 5.6%.

“Hospital procedure volume is a poor proxy for quality in a rural setting, and we need to develop better ways to gauge quality in hospitals overall,” Dr. Meyers said.

In the second study, Dr. Dharam Kumbhani and colleagues looked at 30-day mortality for 10 different surgical procedures in the Veterans Affairs (VA) system. The study was a repeat of an earlier, highly controversial investigation that the investigators decided to revisit, with more recent data. Both studies used data from the VA National Surgical Quality Improvement Program.

The earlier study found no relationship in the VA system between surgical volume and outcome for eight different surgical procedures. The present study,

which looked at procedures ranging from carotid endarterectomy and total hip arthroplasty to pancreaticoduodenectomy, again found no relationship between low volume and worse outcome, said Dr. Kumbhani of the VA Boston Healthcare System.

In 8 of the 10 surgical procedures, there was a statistically significant relationship between low volume and the observed-to-expected ratio of 30-day mortality. However, this difference was not clinically significant, Dr. Kumbhani said.

Moreover, when the data were analyzed using a hierarchical model that accounted for patient and hospital factors, no relationship was found between volume and 30-day mortality.

“We believe that systems of care are much more important than volume in determining the quality of surgical care,” Dr. Kumbhani said. “A lot of high-volume centers have better risk-adjusted out-

comes, not because they have higher volumes but because they have better systems in place.”

The findings of his study are particularly robust and are probably more accurate than other studies of volume and surgical outcome, because the VA program collects all of its data prospectively and was designed for just this type of analysis, Dr. Kumbhani added.

Most of those who attended the presentations were gratified by the results. During the animated discussion period, it was suggested that the studies should serve as a cautionary note to efforts to measure quality solely in terms of volume, because the volume-quality equation perhaps only holds for very sophisticated procedures such as transplants.

However, Dr. Justin Dimick of the Veterans Affairs Medical Center in White River Junction, Vt., who was a designated discussant for the VA study, took issue with generalizing its results. The study’s findings are at odds with an extensive body of research showing that the more a surgeon or a hospital does a particular procedure the better they are at it, he said. ■

Many ‘high-volume centers have better risk-adjusted outcomes, not because they have higher volumes but because they have better systems in place.’