VA Now the Model of Health IT Aspirations

BY MARY ELLEN SCHNEIDER
New York Bureau

Over the last decade, health care within the Department of Veterans Affairs has transformed itself from a notorious near failure to a national model for quality improvement, leaving many asking how they can incorporate those lessons.

The answer may lie in part with the department's electronic health record system. Known as VistA (Veterans Health Information Systems and Technology Architecture), the system recently received the Innovations in American Government Award—a top honor from Harvard University's Kennedy School of Government.

The award was given to seven government programs that each took a unique approach to meeting community needs. All recipients were given a $100,000 grant to share the factors behind their success.

For Dr. Douglas J. Turner, it's clear that the VA is doing something right when it comes to health information technology (IT). Dr. Turner, who is chief of general surgery for the VA Maryland Health Care System at the Baltimore VA Medical Center and is on the surgery faculty at the University of Maryland, Baltimore, has a foot in both the VA system and the private sector.

The VA computerized patient record system contains physicians' notes, lab results, and findings from consults and surgical procedures.

At the University of Maryland Medical Center, he works with at least two different computer systems for reporting patient variables as well as consulting with several different electronic and paper sources to get the information he needs to see patients.

In contrast, at the VA, every clinic is connected in the VistA system with a single patient identifier. "Everything is in the computer," Dr. Turner said.

The VA computerized patient record system, which sits atop the VistA platform, includes the physicians' notes, lab results, and results of consults and surgical procedures. It also generally includes information from visits made outside the system. A hard copy of the clinical record from an outside visit can be scanned into the VA system and made available within a day, Dr. Turner said.

Quality of care has improved since the implementation of VistA, Dr. Turner said. The system includes a check for drug-drug interactions plus several other alerts that let the physician know what's been going on with the patient since the last visit. "Hands down, I would take the VA computer [system] anywhere," Dr. Turner concluded.

VA officials began building the first generation of the computerized patient record system in the late 1980s out of a need to deal with the increasing number of veterans coming into the system, while resources remained tight, said Linda Fischetti, R.N., acting chief health informatics officer at the Veterans Health Administration's Office of Information. "We had to find ways to reduce redundancies and care for more patients."

And the move to an electronic system was driven largely by clinicians who said they needed better tools. "We had clinicians actively saying, 'We need this, we need this, we need this,' " she said.

The idea was to create a single system with robust functionality in every health care environment—the inpatient hospital, the outpatient hospital, the long-term care facility, and clinics within the community. The current system is the second generation and VA officials continue to modernize it, Ms. Fischetti said. Today the system allows VA clinicians access to complete historical information on their patients, as well as real-time clinical reminders and real-time decision support.

The No. 1 lesson from the VA experience is that the system must be driven by the needs of the clinician, Ms. Fischetti said. The system also needs to do more than just replace the paper chart. If the health IT product does not add value for physicians, she said, they might not adopt it.

She noted, however, that the VA, as both the payer and provider of health care services, distinguishes itself from most of the care providers in the United States. "We are definitely different because we have the alignment of the payer and provider within our own enterprise."

While the VA is a unique system, there are lessons that can be applied in large hospital systems and even in solo physician practices, said Tom Leary, director of federal affairs at the Healthcare Information and Management Systems Society.

For example, successful adoption of a health IT system requires buy-in from clinician leadership. While clinician use of a system can be mandated to some extent in any organization, it does not produce the same results unless physicians and nurses want to use the technology, Mr. Leary said.

Other systems can also learn from the VA's approach to designing the system with the needs of its clinicians in mind, said Dr. Dennis Weaver, acting chief medical officer for the National Alliance for Health Information Technology. "You've got to build it for the clinicians," he said.

Automating paper processes doesn't work. Physicians and administrators who are selecting an electronic health record system need to resist the urge to "pave the cow path." They must let clinicians know up front that the work flow is going to change. ■

Health IT Could Create More Malpractice Woes Than It Solves

BY NELLIE BRISTOL
Contributing Writer

WASHINGTON — From a liability perspective, health information technology remains a double-edged sword whose parameters still need to be spelled out, experts said at a meeting on sponsored by eHealth Initiative and Bridges to Excellence.

When it comes to electronic clinical decision support (CDS) tools, Jud DeLoss, vice chair of the HIT Practice Group at the American Health Lawyers Association, recommended that physicians document their reasoning when they disregard the tool's suggestion.

Although it would be "difficult to pull off," attorneys could create a class of victims for whom they argue that clinical decision support was not followed, leading to detrimental results, he said.

Conversely, attorneys could charge that a physician overly relied on the tool "and did not actually engage in the care they said they did."

Attorney Marcy Wilder, a partner with Hogan & Hartson, Washington, pointed out another gray area created by HIT: delineating who contributed what sections to a patient's electronic health record.

"Look at the paper system," Ms. Wilder said. "We have handwriting and signatures, which are simple tools to identify who's responsible for which clinical applications, which provider made the diagnosis, who authorized the medication change. It is both easier and more difficult to do that with electronic health records."

The simplicity and efficacy of identity authentication "is going to depend upon the extent to which the vendors that are building the systems get this right," according to Ms. Wilder.

Although systems are in place to address identity authentication in health care institutions, problems may arise when data from shared information warehouses--such as a regional health information organization--are incorporated into an electronic medical record, Ms. Wilder said.

"That's where it's going to be very messy, and I think it will be a long time before we are going to be using shared data warehouses in part because of those kinds of liability issues," she said.

Mr. DeLoss and Ms. Wilder added that as use of electronic medical records grows, physicians may have a duty to be familiar with a patient's entire medical record if it is available.

In their contracts with hospitals, physicians spell which party is liable for problems that arise from software donated to them by hospitals. ■

Rheumatologist Tweaked Voice Software to Save Time, Money

BY BRUCE K. DIXON
Chicago Bureau

If you're frustrated with the expense and delays of Dictaphone transcriptions, Dr. Jonathan Krant's solution may be just what the doctor ordered.

"Until 5 years ago, I utilized a Dictaphone with off-site transcriptions [at a monthly cost of $3,000], a process that resulted in chart and referral consultation notes taking a week or longer to get to the referring physician," said Dr. Krant, a rheumatologist in Pittsfield, Mass.

Dr. Krant invested $4,000 in an off-the-shelf version of Dragon Systems Medical Suite and a sophisticated Dell computer system. "I customized the voice recognition software with a rheumatology lexicon of about 10,000 words and corrected mistakes in real time on screen," he said.

"Now, 5 years later, there are no charts on my desk. Follow-up appointments and new patient consultations are dictated at the time of service into either a portable handheld unit or a microphone connected to the computer. I can send either faxed notes or dictated copy with a keystroke [with] over 99.5% accuracy," explained Dr. Krant, who has no financial interest in the technology.

And his practice has tallied up savings of $180,000 ($3,000 a month for 60 months).

"Several years ago, I spoke with Kim Bruce, then chair of computer science at nearby Williams College, about the advantages and pitfalls of vocal recognition software," he said. Further investigation revealed that the Modifying the Dragon Systems Medical Suite had a tolerable error rate and could be modified to fit Dr. Krant's rheumatology practice needs.

"It took me about a month to create a database where I would dictate into the computer. A word would come up and I'd change it, then speak the word. For example, 'sedimentation rate' may come out as 'sentient rate'; that could be corrected in real time using the keyboard and [microphone]."

After several thousand entries and corrections, his system became a valuable tool in his practice. "It's fast, accurate, and even recognizes my voice when I have a cold or pharyngitis. Entire phrases and chart notes can be set up using templates that have assigned identifier numbers, so all I have to do is say the number and there's the phrase or chart, lickety-split."

Dr. Krant receives referral patients from about 200 primary care physicians. He's now able to get his notes to them within 10 minutes of seeing a patient, making evaluation and therapeutic intervention almost simultaneous with the patient visit.

"If I've got a patient with leg swelling and his physician thinks he's got an effusion in the knee because of arthritis, but I'm concerned about a clot in a lower extremity, I have an ultrasound waiting to be performed and an admission pending for deep vein thrombosis lined up within 15 minutes of the patient's examination," he said. ■

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