VA Health IT Experience Offers Innovative Lessons

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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 private sector.

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 physician's 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 that we could 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,' " Ms. Fischetti 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 succeed in adding 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.

Success also depends on getting a return on investment—improvement in quality and cost effectiveness of care—as seen in VistA.

These ideas are applicable as well to the small practice, Mr. Leary said, where the return may be an improvement not only in quality of care for patients, but also in quality of life for providers. Physicians have the opportunity to provide better care, without, for example, having to drive back to the office on the weekend to answer a call about a patient, he 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.

But that doesn't mean just automating patient charts, he said, because recreating 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 workflow is going to change. ■

POLICY & PRACTICE

College Psoriasis Campaign

The National Psoriasis Foundation is seeking to increase awareness and knowledge about psoriasis among college students, partly because the disease usually first appears between the ages of 15 and 25 years. The College-Age Psoriasis Awareness Campaign will be anchored by television news segments provided by the foundation that feature Dr. Stephen Feldman, professor of dermatology and pathology at Wake Forest University and a 21-year-old psoriasis patient and college student discussing the physical, social, and psychological consequences of the disease. "Misperceptions about psoriasis can negatively affect [college students'] comfort level with dating, participating in sports and going on job interviews," said Gail Zimmerman, Psoriasis Foundation president and CEO, in a statement. "The goal of CAPAC is to educate this group and alleviate the potentially adverse social effects of psoriasis," she said.

Cosmetic Surgeons' Calif. Victory

A California judge has ruled that the state's Medical Board must grant equivalency status to the American Board of Cosmetic Surgery (ABCS). The decision by Judge Jack Sapunor in the Superior Court of California, Sacramento County, means that the ABCS would be given the same footing as other boards recognized by the American Board of Medical Specialties. The Medical Board of California had refused applications for equivalency by ABCS in 1999 and again in November 2005. That meant that cosmetic surgeons in the state could not use the phrase "board-certified" in advertising, and that they had difficulty getting hospital privileges, according to the American Academy of Cosmetic Surgery. The ABCS challenged the Medical Board's decision, calling it arbitrary and capricious. The Judge agreed and said that the ABCS met or exceeded the requirements. The Medical Board is appealing. The AACS said that the ruling could pave the way for equivalency in other states.

AAD Targets Indoor Tanning

The American Academy of Dermatology is launching a public service campaign on the dangers of indoor tanning using teen-centric instant-messaging shorthand. The print, television, and radio ads use language typically employed while "IM-ing." According to the AAD, 70% of indoor tanning customers are white females aged 16-49 years. "This campaign is to specifically target teenage girls at a young age before they start tanning and educate them in a peer-to-peer manner that will encourage them to avoid this unnecessary health risk," said Dr. Arielle N.B. Kauvar, chairman of the AAD's Council on Communications, in a statement.

CMS Curbs Improper Claims

Medicare's on track in 2006 to further reduce the number of fraudulent and inappropriate claims being submitted. The Centers for Medicare and Medicaid Services reported that 4% of claims were improper in 2006, down from 5% the previous year and from 14% in 1996, leading to $11 billion less in improper payments over the last 2 years. To determine the error rate, CMS randomly sampled 160,000 claims submitted from April 2005 to March 2006. Since it has been able to more closely identify errors, CMS has been providing more accurate information to contractors, resulting in improved system edits and updated coverage policies, the agency said in a statement.

Ex-FDA Chief Guilty

Former Food and Drug Administration Commissioner Lester M. Crawford, D.V.M., has pleaded guilty to lying about stock he held during his tenure, in violation of federal conflict-of-interest and stock ownership rules. Dr. Crawford was charged with two misdemeanors and is scheduled to be sentenced Jan. 22 in Federal District Court in Washington. He could receive a year in prison and could be fined $200,000. According to the plea, Dr. Crawford failed to sell shares in Sysco, Pepsico, and Kimberly-Clark, all of which have products that are regulated by the FDA. Federal rules require senior officials to divest shares in companies that their agency regulates. Dr. Crawford also did not disclose his wife's ownership of Wal-Mart stock. Dr. Crawford was charged with conflict of interest for owning the Pepsico and Sysco shares while he was chairman of FDA's Obesity Working Group. Rep. Maurice Hinchey (D-N.Y.) said he will push for a completion of an Office of Inspector General inquiry into Dr. Crawford's resignation and financial holdings. "Based on Lester Crawford's apparent disregard for the law, we must find out what other improper actions he took while leading the FDA, which may not necessarily have been illegal, but were inappropriate or unethical," Rep. Hinchey said in a statement.

McClellan Accepts Think Tank Post

Former Medicare Chief Mark McClellan has accepted a new post as a visiting senior fellow with the AEI-Brookings Joint Center for Regulatory Studies in Washington. The new job will keep Dr. McClellan involved in health care policy issues. He also will remain as an associate professor of economics and an associate professor of medicine at Stanford (Calif.) University. Dr. McClellan had been on leave from Stanford for several years while working in the federal government. Before taking the post as administrator of the Centers for Medicare and Medicaid Services, Dr. McClellan served from 2002 to 2004 as the commissioner of the Food and Drug Administration. He also served as an economic and health care advisor to President Bush from 2001 to 2002.

—Alicia Ault