

Government FACA Blog EHR Public Opinion Posts

F. Ray Nickel, MD says:

www.venturaorthopaedics.com

October 29, 2009 at 8:54 pm

We are a 12 man orthopedic group who implemented a full PMS/EMR on March 1, 2007.

The primary benefit to our organization has been the ability to exchange patient information among our 6 offices, as well as general communication within the organization. **The negative has been a drop in physician productivity of 20-30%, commensurate with published studies.** This has occurred in spite of extensive use of templates and speech recognition and is unlikely to improve in the near future. Furthermore, there is no evidence that there has been any improvement in patient care. There has been improvement in documentation, but not patient care. Any belief that increased usage of EMRs is going to have any national benefit which should be encouraged on a federal basis can be held only by individuals who have no experience with these programs. The decision to implement such a program should be left to the individual business entity as a business decision, not as a patient care decision.

Scott Lagaard says:

October 30, 2009 at 8:38 pm

I do orthopedics in a large, multispecialty group. We have been on Excellian (a version of Epic) for three years. **It adds 45-60 minutes per half day of clinic patients.** As a specialist, I found little good for me in this system, but many frustrations and slow-downs. For my patients, the EMR is marginal (my help or hinder them), but for me the electronic record system is inefficient and hateful!

Kenneth Low MD says:
November 9, 2009 at 8:32 pm

I unfortunately made the mistake of converting to a drop and point system and found it too impractical for the following reasons: **took too much time and took away from actual patient time** (patients would try to catch my eye so that I would look at them), inability to actually input the descriptions like I would on paper, took too long to review old notes, unable to draw accurate drawings.

I ditched the program after spending over \$100,000 in time and equipment on this system. Patients were complaining that they could not get in to see me because I could not see my normal schedule of patients!

A custom hybrid system that I switched to was much more practical and user friendly.

Paul Luetmer says:
November 16, 2009 at 7:15 pm

We wasted a ridiculous amount of money purchasing and training to use a traditional EMR. We had a **huge decrease in productivity.** Even worse is that **EMR notes are almost completely useless.** They contain only a fraction of the information of a dictated note. Much of what is there has only the appearance of being meaningful and often has no actual basis in reality. These notes do not transmit any of the subtleties of the patient's condition. **In the end we had to discard our EMR for a total loss.** (This was a "brand name" highly recommended system and was not cheap.)

When we went to SRS (a hybrid system) training time was 10 minutes per doctor. The first day of use the doctors saw full schedules of patients. We now have increased productivity, and the quality of the notes and information in the chart is improved, not degraded. The hybrid SRS system needs to be CCHIT certified.

Amy Russell says
www.sportsmedpartners.com
November 10, 2009 at 10:07 am

We recently came off from using AllMeds for our EMR. **We found it to be very tedious with numerous clicks** to get to the area we needed for documentation. The most frustrating part was not being able to customize certain areas. We had to choose from the list provided, and at times, it did not provide adequate description of how the injury occurred. **The end result office note was very canned** and many of the Primary Care physicians felt it was too much info. After numerous attempts to try to get things to work, the negative impact on the flow was enough for us to walk away. It was costly both in terms of time and money.

Theodore Curtis, MD says:
October 30, 2009 at 2:48 pm

I have had the “opportunity” to use three different EHR systems (all from implementation) at my last job.

All of them had huge gaps, especially as a specialist. **I found that I needed an extra 5 hours per week to finish documentation. And on top of that, my productivity permanently dropped.**

There were some benefits, but all on the retrieval side. On the data acquisition side, things were slowed dramatically. Also, patients were unhappy that I was spending more time on the computer than looking at them.

I’ve looked at all the major players and talked to dozens of practitioners. Only people who use hybrid systems seem happy.

Bill Pupkis says:
www.capitalregionorthopaedic.com
November 11, 2009 at 10:06 am

This is a group of 29 Orthopaedic surgeons who have more than 100,000 patient visits a year. We have looked for a number of years and are now close to making a decision on an EMR. Our decision will be similar to what Dr. Bynoe described as a document-centered system. This type of system would give the physicians access to all of our patients’ records within seconds rather than having to wait for someone to retrieve the paper records either in our medical records room or in storage. And when the physicians are on call they would still have access to the electronic documents whereas with a paper system they do not.

The data-centered type systems will not help our physician to provide better medicine. In fact, these systems do little more than **force physicians to become data entry clerks using a point and click method with templates**, which have a tendency to produce clone like medical records, all sounding the same. Plus, a fully implement the data-center system is known to slow physicians down, i.e., they cannot see the same number of patients, at least for Orthopaedics and other subspecialty type practices.

Burrel Gaddy, MD says:
www.midwest-orthopaedics.com
November 12, 2009 at 7:14 pm

Our group looked at several EMR’s before making the decision to implement. I learned a great deal in the process, and came to some conclusions that surprised me. The first was that, while extremely powerful, **full EMRs are too much of everything for a specialist. Too much data entry, too much to look at, too much navigating through a patient visit.** And we also already knew that we could spot letters from referring doctors using full EMRs in a heartbeat,

and we did not like them. They are very long, clearly templated, and we came to doubt the information. We also had heard of colleagues who implemented full EMRs and saw their billed charges and collections decrease due to **loss of productivity**, a side effect they had not counted on.

After looking at several EMR products, we selected a hybrid EMR, and have been extremely pleased. We did not lose any efficiency and now have access to information faster and more efficiently than ever before. While initially skeptical of ROI claims, I can now see that we continue to become more efficient and have lost many of the costs we had before.

“Meaningful use” must be defined to include and understand specialties. **Right now, even if we had purchased a CCHIT-certified EMR, we would not come close to qualifying for meaningful use, and if we elected to try to qualify we would certainly have to balance any increased HITECH dollars against a loss of productivity** because of having to track and report on numerous data elements that are simply not relevant to the work I do. Meaningful use is currently very primary care focused, and unless the specialties are heard and understood it will be foolish for us to pursue qualifying for it.

Barbara Sack says:

www.midwest-orthopaedics.com

November 2, 2009 at 2:42 pm

After researching EMR's for over 5 years and listening closely to colleagues who had implemented them, we chose a hybrid EMR (SRS) for our very busy orthopaedic group. While we have participated in the other federal incentive programs successfully, **the stimulus money for “meaningful use” of a “certified EMR” is simply not worth the costs to implement.** Even though I had several quotes for full EMRs and could have purchased one for the same cost as the hybrid, **the loss of productivity would have cost as much or more than the potential return.** Not only would the physician have to completely change their practice pattern, they would also have to begin tracking and reporting on things that currently do not have any relevance to orthopaedic care.

Much of the relevant information needed can be found in the Practice Management systems, with the physician documentation (office note) being the exception. We can share office notes easily from within the EMR.

I've known several groups who have implemented full EMR's only to yank them out because of the difficulty in using them, the loss of productivity and the way it forces them to change how they see and interact with patients. We had no loss of productivity at all – didn't reduce the schedule by even one patient, and the physicians now have easier access to the information than they ever did before.

Barbara Sack, MHSA, CMPE

Richard S Boss, MD says:
October 30, 2009 at 2:09 pm

Pine Medical Group, a 20+ provider multispecialty group in Fremont, MI has been using an EHR hybrid system (SRS) since August 2006. It was not, nor is it now CCHIT certified, and thus by the current criteria does not qualify for any stimulus incentives. However, it is second to none in function. It is not template driven, but does probably 95-99 % of functions that a traditional EHR does. The big difference from traditional EHR's is that it works!

We went live on August 9, 2006. I blocked out 50% of my schedule for the next two months as I expected a major drop in productivity, after hearing all of the horror stories of my regional colleagues. On August 11, 2006, just two days later, I opened up my schedule fully and have never looked back. Our practice literally had no down time and absolutely no drop in production.

Function, ease of use, effective documentation, and reasonable cost of operation should be the primary focus and considered of utmost importance in any EHR. It is my hope that as "meaningful use" continues to be developed, that we don't shoot ourselves in the foot by ignoring some very basic areas, and a system such as ours, which works, should at least be seriously considered as meeting criteria.

Richard S Boss, MD

Cheryl Pador says:
www.muani.com
November 13, 2009 at 12:55 pm

Our six-physician urology practice is an extremely busy one! For nearly nine years, our office has been running on a hybrid EMR solution. This electronic solution allows my physicians to maintain their high-volume schedules while allowing them to continue practicing medicine on their terms. Our hybrid EMR provides instant chart access, electronic prescribing, and messaging & tasking even though it's not a traditional point-and-click EMR. **If my physicians were forced to use a traditional point-and-click EMR, the loss in productivity would be staggering!** They would need to decrease the number of patients seen in a day and for our practice, that's just not an option.

Jasmine Erman says:

www.muanj.com

November 13, 2009 at 2:55 pm

One of the final criteria for meaningful use should be centered on the software's 'user-friendliness.' Trying to force physicians into products that are not designed to fit their current workflow would result in disastrous implementations. **Our physicians are extremely busy and forcing them to use a traditional point & click EMR would dramatically reduce their productivity and they'd have to curtail the number of patients that they could see in any given session.** Our current system is a hybrid EMR that has allowed our physicians to maintain their current patient volume by not changing the way they see and interact with patients. The hybrid EMR still provides immediate access to charts, data-bases lab results, creates prescriptions and manages messages, but it does so in a way that does not interfere with, but rather enhances our office's productivity.

Peggy Dorriety, Practice Administrator says:

www.rivercityortho.com

November 12, 2009 at 2:38 pm

We chose not to purchase a traditional EHR because we didn't want our physicians wasting their time creating a document through pull down menus, or point and clicking on templates that they would have to build. We did not want to change the way our physician workflow was conducted. Instead we wanted to enhance it. That is why we chose a Hybrid EHR.

I believe that an EHR should provide an efficient way to view the patient's records. It should have the capability to electronically send the records, in a secure way, quickly to other providers that need them. An EHR should compliment how a provider's workflow is conducted, since his/her time is the most valuable resource within the office.

Jea'n Oubre says:

November 17, 2009 at 9:03 pm

We have a large cardiology practice (Approximately 40 providers, 550 users and 10 office locations). **We purchased a point-and-click EMR, but in a very short amount of time we found it to be a tremendous challenge** and our physicians could not treat the same volume of patients. **The physicians had essentially become data entry clerks.**

In 2008 we replaced our point-and-click system with a hybrid EMR which has been very successful in our practice and embraced and adopted by all providers and staff. We implemented the hybrid EMR throughout our entire organization quickly and easily – it was a very smooth transition. With the new system, we have the full benefits of instant patient chart access, efficiency, and better patient care.

Because of the smooth transition, our employees were much more receptive to the change and our physicians were receptive to viewing patient charts in a 100% digital format.

Overall, the benefits of a hybrid EMR have proven to be:

1. Physicians do not have to change the manner in which they have practiced for years.
2. The organization does not lose revenue due to a decrease in patient visits.
3. Easy “buy-in” from providers and employees.
4. A more efficient practice that is more attentive to patient needs.
5. Higher quality patient care.

Thank You,

Jea'n Oubre LPN
Senior Health Information Specialist
Houma, Louisiana

Deborah Brown says:
October 30, 2009 at 10:11 am

We have put in the time and money, **over 200K to implement an EHR system**, after over a year of looking, comparing and training. **It just didn't work**. We went live in March 09 and by Aug 09 we had stopped using the system. The software updates and maintenance fees were very expensive and charged on a monthly basis which actually cost more per year than buying the software. You don't know how something is actually going to work until you implement it. We were ready for a slowdown, but our **doctors went from seeing an average of 30 patients a day to 5 or 6**. You can't do that for any period of time and stay financially sound, none of those things are being taken into account on the little proposed government re-imburement. We also made a big investment in upgrading, or purchasing new hardware. The systems don't talk to the hospital, labs, other doctors. We were told there would be a small fee for setting those things up, that small fee turned out to be 15K per link. It was an unaffordable mess, even after all the due diligence that was done.

Mark Steele, M.D. says:
November 9, 2009 at 1:19 pm

It is crystal clear what this country needs to do to harness the power of technology in the medical record arena. As a physician I have been on the front lines of health care delivery for nearly 20 years in private medical practice. I know what would cure the ills of paper medical records, and it certainly isn't traditional "point and click" data entry EHRs. One only has to read the comments already posted by frustrated physicians and administrators to understand why this type of EHR is not the solution.

The nationwide EHR adoption rate is very low, and **deinstallations are becoming commonplace—simply because traditional EHRs don't work. They force physicians to become data entry clerks and diminish their productivity**, which not only decreases practice revenue, but also reduces their ability to meet the increasing demand for care. **Quality of patient care also suffers**—forced quantification of complex human conditions into discreet data entry fields loses the nuance integral to delivery of excellent care.

The solution is a very "American" one. If you let the free marketplace operate as intended, the technologies that rise to the top will be those that physicians find usable. While they might not meet "meaningful use" requirements in their present form, they will meet physicians' demands for streamlined workflow, increased productivity, and delivery of excellent patient care—and they will be successfully adopted.

There are, however, some Health IT aspects that HHS should require. Electronic Rx should be mandatory because of its ability to eliminate duplicate costs and increase patient safety. Its success to date is directly related to its positive impact on clinical workflow and consequent acceptance by physicians. The government should also run the personal health record business. A better and more

meaningful alternative to an interoperable data mine of massive clinical information from health care provider encounters would be a federal database of patient clinical problems (a simple list of diagnoses), medications, allergies, diagnostic study data bank (e.g., blood tests, MRI images, etc.) This is all a cross-treating physician needs and is what HHS should be striving to achieve. The cost savings from this federally-hosted personal health record would be huge, as duplication of expensive testing would end. Better patient care would be the result.

HHS should not concede to anecdotal data and misleading marketing proliferated by the big traditional EHR corporations. HHS should not be promoting adoption of old technology—the clunky, data-entry EHRs that are doomed to fail. The HIT Standards Committee must rise above the delusion that data-entry EHR works and shift its focus to realistic, achievable goals that would actually help the American taxpayer to whom it was chartered to service.

Jim Hammonds says:
November 4, 2009 at 9:57 am

In order for any government sponsored EMR for physician practices to be widely utilized and accepted, “meaningful use” needs to be expanded to “meaningful OPERATIONAL use”. **Even if an IT system were free to a physician’s practice, but it required him/her to see two less patients per day, then its’ ultimate cost would be anything but free.** We did extensive research in this area among available EMR systems and carefully chose SRS “Hybrid EMR” for my busy Orthopedic group for this very reason. **Physician time is a practices’ most valuable resource and it’s not efficiently allocated in the completion of templates.** Also, Group Administrators who want to keep their jobs in the future are going to have to be able to cut overhead, particularly in the area of FTE staff. This task will be nearly impossible to accomplish without an EMR system that’s built around “meaningful OPERATIONAL use” as is SRS.

Nick Benoit says:

www.cardio.com

November 10, 2009 at 5:49 pm

Finding and implementing an electronic medical system proved to be both an undertaking and an accomplishment for our practice, Cardiovascular Institute of the South. With 11 locations throughout southern Louisiana, close to 50 providers and nearly 500 team members, CIS averages about 195,000 patient visits per year representing every specialty in heart and circulatory medicine.

Our practice consistently positions itself at the forefront of patient care by utilizing the most up-to-date technology coupled with compassionate care. To stay consistent with this mission, we chose a vendor that was interested in developing a cardiology-specific traditional 'point-and-click' EMR system to replace our paper-based chart system. Though the collaboration was a success, soon after implementation we hit a roadblock. **The point-and-click system became too cumbersome and time-consuming to maintain. It was unrealistic to expect our physicians to slow down their processes and decrease their productivity by inputting such detailed information into the system.** The whole nature of this point-and-click EMR system did not fit CIS' workflow.

Once we realized the need for a different solution, we went back to the drawing board. After months of searching, we found a solution that seemed to be a perfect fit. That solution was a hybrid EMR system that had been specifically designed for high-volume and high-revenue practices. This system focuses on productivity and allows the physicians & staff to streamline and enhance their current workflows.

Our hybrid EMR system does not require complex physician data entry but has a robust digital chart management engine that works simultaneously with powerful data management and workflow modules. These modules address electronic messaging, e-prescribing, PQRI alerts, reporting and reminders, outcomes tracking, order management, and, of course, simple chart access.

Overall, our hybrid EMR system creates a 100% digital practice, with universal access to all patient information. It also increases quality of care and maximizes efficiency without hindering the way our physicians practice medicine; and it allows our staff to spend more time with their patients. This efficient flow of pertinent information, communication, and collaboration gives CIS the ability to provide world-class patient care...now and in the future.

Kathleen Wells says:

www.scoi.com

November 13, 2009 at 5:25 pm

After extensive evaluation and testing we choose to bypass the unsuccessful traditional EMR and to implement a Hybrid EMR. Following a very easy two month installation and a very short training period for our providers, the system was in place and working as intended. Our providers love the easy access to patient information and the efficient flow of information and messages through the system. The system paid for itself within the first year. The Hybrid EMR did not decrease our provider's productivity...and it really does contribute to better patient care. This is the sort of system on which our tax dollars should be spent.

Heather Giddings says:

November 13, 2009 at 10:43 am

I am the Health Information Manager of a busy cardiology practice with 20 providers. **A few years ago we had a failed implementation of a point and click EMR. The processes and flows were way to cumbersome. It slowed the process for providers to see and evaluate patients. They were required to point and click their office notes and the format was very hard to understand.**

We did a lot of research before finding a hybrid EMR and am happy to say we are now chartless. With this hybrid EMR (SRS) we can ePrescribe, we have integrations with a lab, protime and dictation system, and it has excellent scanning and electronic messaging capabilities. We are a much more efficient office without the paper charts. Providers have very little data entry to do with this system so it doesn't slow them down.

This is the way to go. I hope that when the HIT Standards Committee evaluates the options that this type of program is highly considered.

James McAnally says:

October 30, 2009 at 12:07 pm

I have been in the private medical clinic business for 33 years. Most of those years have been with specialty practices. **It was apparent approx 10 years ago that specialty practices would not easily adopt "point and click" EMR systems because of the loss of time by those practitioners.** Document management systems can meet all of the requirements and help implementation of a paperless system. All studies so far in evaluating how practitioners are able to implement indicate primary care more easily accomplishes the point and click system buy specialists do not. There are so many reasons not to force physician practices in a structured environment as it relates to this topic but the primary one is that patient care will suffer.

Wayne E. Fung, M.D. says:
November 6, 2009 at 6:20 pm

Our Corporation, The Pacific Eye Associates, consists of 13 Ophthalmologists covering the subspecialties of Retinal Diseases, Cataracts, Diabetes, Glaucoma, Uveitis, Pediatric Ophthalmology and Uveitis have had the Hybrid SRS system for five years. It is a scanning system as opposed to a typing system or a "hunt-and-punch" system. We see an average of 250 to 300 patients/day.

Each patient is seen with a bar-coded sheet; we take a brief history, make sketches of our anterior or posterior segment physical findings, enter our diagnosis, treatment plan, and recommendations. At the end of the day, staff scan each page and that page is electronically combined with the patient's existing record instantaneously. The paper is recycled. We do not need "scribes" or secretaries following us to make notes. Because sketches are understood by everyone reviewing a colleagues notes after hours or on weekends is not a problem.

We have tested EHR systems with stylus methods and they cannot be colored the way a colored pencil can do.

Kim V Powell says:
November 5, 2009 at 2:47 pm

It is imperative that any EMR be used by physicians. Point and click systems favored by most vendors and CCHIT are not well accepted by physicians. In my experience, **the reason for poor acceptance rates is the slow down of physician productivity and decrease in the number of patients that can be seen**, because these systems require the physician to perform much of the work necessary to submit claims. This is a poor use of physician time. Physicians in high volume specialties (primary care, cardiology, dermatology, etc.) are most affected by this problem. In our dermatology practice, we have chosen the SRS Hybrid EMR precisely because it does not interfere with the physician's ability to see patients. Our physicians can still see 40-60 patients a day, provide them with personal, quality care, and achieve the benefits of EMR. We have ePrescribing, order tracking, in-office messaging, and the ability to store and retrieve medical chart information.

Joseph Alhadeff, M.D. says:
November 11, 2009 at 6:28 pm

I have now worked with 6 different EHR systems, practice and hospital based. The crucial issue to implementation is how to deal with data entry. To get the full benefits of EHR, all of the medical data for each patient has to be electronically entered. Scanning documents, while good for an individual practice to go paperless, is next to useless for interoperability and data transfer. Data entry is extremely time consuming and fraught with errors. If the physician is the one entering the data it takes valuable time away from the patient. If someone else enters the data, there are concerns about accuracy, and there is the significant question of who should pay for the increased cost of data entry, whether it is the physician's time or someone else's. At present there are multiple EHR systems that don't communicate well with one another, so the same time consuming data entry process is repeated at every practice – wasting immeasurable resources. What we need the government to do is identify a core set of critical medical information, and then set a format, that can be easily transferred between practices. For example, a patient's past medical and surgical histories, hospitalizations, their medications and allergies, need to be stored in a format that is recognized by all EHR's so that information can be readily transferred from one practice or environment to another. We don't need the government storing information, just establishing the standards and then stepping back and letting the various companies create the products. This would reduce some of the data entry burden and make EHR's more attractive.

A second issue is the sheer volume of medical history information being generated. The requirements for documentation for reimbursement for services have become so onerous that I would estimate that 85% of the content of all medical notes currently produced is unnecessary. I constantly find myself shuffling through pages of electronically generated medical history to find the two or three crucial sentences that I really need. The rest is there merely for billing purposes. Looking back at medical charts one can read pithy paragraphs that summarized the patient's visit and conveyed the necessary information in a brief synopsis. Now, every little thing must be documented, so that we spend nearly as much time writing about what we do, as we spend doing it. Notes that used to be a paragraph, are now pages long, and filled with unnecessary data.

Rob says:

www.poamd.com

November 12, 2009 at 3:52 pm

Like many others I too have work with and tried many EMR's and it is clear to me that the standards as proposed by the committee will simply not work for the great majority of healthcare providers in this country.

Dr. Alhadeff, in his post above is completely correct, what we need is "for the government to identify a core set of critical medical information, and then set a format, that can be easily transferred between practices " and I would add between systems. Without standards that are clear and reasonable the government system will fail. As everyone knows **the successful implementation of tradition EMR systems is alarmingly low.** Those practices that have succeeded have had to go through a tedious and painful restructuring of their workflow. All of this work in an effort to gather more information (is it really needed?) and to provide better patient care?

After extensive evaluation and testing we choose to bypass the unsuccessful traditional EMR and to implement a Hybrid EMR. Following a very easy two month installation and a very short training period for our providers, the system was in place and working as intended. Our providers love the easy access to patient information and the efficient flow of information and messages through the system. The system paid for itself within the first year. The Hybrid EMR did not decrease our provider's productivity and it really does contribute to better patient care. This is the sort of system on which our tax dollars should be spent.

Christopher Taylor, CMPE says:

www.valleyoakorthopaedics.com

November 10, 2009 at 6:35 pm

I agree with many of the posts on this blog and appreciate the opportunity to be heard by the committee. I'm the administrator for an orthopaedic surgery group located in Northern California. **Our physicians attempted to use a traditional point and click EMR back in 2004. Over the last 5 years we spent countless hours and money and training that never amounted to any real progress.** We eventually began to use this system as a document management system. Because of the limitations of this EMR we decided to purchase a hybrid EMR that would meet our needs and not the needs of someone else. I'm happy to report that our current system has allowed our productive physicians to maintain the same volume of patient and benefit from all the streamlined processes and well designed system has afforded us. Our patients and the communities we serve also benefit for many of the features of our hybrid EMR system. Please consider the benefits of these systems as you move forward in this process

Kevin Cranmer, MD says:

www.norwichlasik.com

November 13, 2009 at 3:19 pm

I definitely agree that any standards the government publishes need to be generic. I am a busy ophthalmologist in Connecticut, and I use a custom EMR that works very well for what I do. **If I had to use a primary care EMR, I would have to cut my patient load by at least 30%**, simply because the information a primary care EMR gathers has nothing to do with what I need.

Thank goodness we're not going to have to submit to CCHIT certification for specialty EMRs. I hope that HHS does not try to replicate the CCHIT standards. We need generic standards that address interoperability, privacy, and security, and do not try to micromanage what the EMR does. CMS already has requirements for what documentation is required, and any practitioner who uses an EMR can easily make sure that his/her EMR fulfills those requirements. Trying to shoe-horn all the specialties into one standard would be a disaster.

Jon B. Tucker, M.D. says:

www.tuckerorthopedic.com

November 11, 2009 at 10:30 am

I implemented a CCHIT certified EMR system about 18 months ago. The system affords document management, dictation, point and click, pen based, typing, and speech recognition.

I found that **the system does not improve productivity, and it requires additional staffing during office hours in order to meet the real time data entry requirements lest the practice fall hopelessly and irretrievably behind in documentation.** Perhaps interoperability, web portals (still a promise) with patient data entry will eventually help. I doubt it, though.

Preconfigured physical examinations in the point and click environment are helpful, but at least in orthopedics fail to capture and convey important information that requires additional and for most people objectionable amounts of additional data entry.

We intend to continue the EMR system but I have concluded that physician level data entry tasks with most EMR systems are not sustainable, efficient, nor practical. I will be moving away from that paradigm in the near future, having tried it for the past 18 months with ongoing frustration at the productivity bottleneck imposed by it.

Frankly, I'm hopeful that my new computer with a 64 bit processing environment and windows 7 will do a better job in combination with Dragon 10.1 Speech recognition with 32 bit processing and XP was lousy. Tablet PC configuration

was worse. It's good that I can type, thank heaven for 10th grade typing class, at this point it was a lot more useful than my sports medicine fellowship.

Please remember that all EMR systems are basically kits that require a lot of user assembly and configuration. You can't expect a shrink wrapped product. It does not exist. Federal regulatory activity and policy will inevitably fail to produce the wanted results even with the best intentions.

Lorraine C Woods FACMPE says:
November 13, 2009 at 10:56 am

I am come into this discussion with a somewhat unique perspective. While currently in practice management I have worked in case management / UR and QA in both the hospital and payor setting and have been responsible for network development for a large national PPO. I have also assisted on the design of software systems for all these products.

Today we are discussing 'meaningful use' – essentially how to collect data. Yet most of us who have looked at years of data already collected realize most of it falls into the 'garbage in- garbage out' arena.

To design effective EMR systems for all specialties – one must first endeavor to find the 'least common denominator' i.e., the minimum dataset that ALL providers collect and use. The detailed information needed by an internist, an orthopedist or an ophthalmologist are very different yet vital to their respective specialty and most importantly meaningless to each other. Docs need to share diagnosis... the ophthalmologist may not remember what a 'negative lachman' means!

One of the lessons we should have learned is that the more you force the collection of data – the less meaningful the data become. .. who produces the data, who enters the data — and most importantly who certifies the accuracy of the data..

Currently I am the practice administrator for an orthopedic group. They chose a document management system before I joined them in 2001. The past eight years have served to prove they made the correct decision. The system was easy to implement, training time was minimal and yet the system has served to make all members of the practice – both clinical and administrative more productive. Over the years the system has been upgraded to a more hybrid EMR where minimal data entry can be used for order management and other tasks while maintaining the productive workflow in a busy orthopedic practice.

A number of years ago we did look at a 'real' EMR system with templates, point and click data entry – all the bells and whistles— and we realized that implementing that type of system – for our practice- would dramatically and negatively affect the productivity of all. We elected to remain with the hybrid EMR – automating what we can while not impeding the productivity of the physicians who are the prime users of these systems. While a full blow EMR may be useful in some specialties — beware trying to make a one size fits all...

Rebecca Hockaday says:
November 13, 2009 at 6:45 pm

I am a huge fan of hybrid EMR (SRS). I firmly believe that a hybrid EMR should be CCHIT certified. A true EMR product did not work for our office because it took too much time to document a visit requiring less patients to be seen which is not good patient care. It also takes longer for a patient to be seen and patients are not happy with this because their time is valuable also. A hybrid EMR is so similar to a full EMR but a lot of the normal fashions a physician operates under today allows them to continue in that same fashion which is very important as a lot of physicians, especially older ones, do not like change.

Tim Logemann says:
www.canw.org
November 14, 2009 at 5:03 pm

I am a member of a 12 man 18 provider cardiology group in Wausau, WI. We have been very pleased with our hybrid EMR. We were able to implement it with very little practice or patient disruption. We did not have to cut back on our schedules and this allowed full patient access throughout the implementation phase. Our SRS populates the EPIC program at our hospital so all our notes and test are available when necessary to the ER and inpatient services. The ease of use resulted in great provider acceptance and adoption. The ease of access has afforded great patient service and safety from any site. Hybrid EMR's need to be accepted and CCHIT certified

Rita says:
www.danortho.com
November 11, 2009 at 10:57 am

As the manager of a very busy, and productive, orthopaedic practice, I am extremely concerned about the effect of a government-mandated standard of a "point-and-click" or templated medical record will have on this practice. The physicians here dictate their notes for each patient and no template can improve the quality of their documentation. I certainly see the value of a "paperless" office for patient care and efficiency, but that can be achieved by a document management product much more effectively for this office. I hope that the government will be responsive to these voices saying that we know how to best document the care given to our patients.

Arthur Allen MD says:
October 30, 2009 at 3:00 pm

We have the largest private ophthalmology office in San Francisco and see upwards of 200 patients a day. We have been using the Hybrid SRS system for several years and it is terrific. It does not slow us down, there is no “boiler plate modules”, it can be accessed from any office and at home, it is secure and most importantly it works! **Over the years we have looked at other EMR’s but they all would significantly slow us down in seeing patients and are oriented towards primary care.** The SRS system allows us to draw details of the patients exam which is very important in ophthalmology.

I encourage you to certify this excellent system for specialties that don’t fit the usual EMR mold.

A W Allen MD

John Lynn says:
www.emrandhipaa.com
October 29, 2009 at 7:22 pm

One suggestion I’d make for a future blog post is a summary of the ways that the public can participate more fully in the discussion happening in these committee meetings. Certainly this is a great new avenue in the comments, but a simple summary with links on how the public can effectively submit comments to the committees would be great.

With the concept of standards, I think it’s essential to keep them simple and meaningful. We don’t have to solve EVERYTHING on first whack. It would be better to be interoperable with allergies and meds than to try and exchange entire health records and end up exchanging nothing.

George Benyak says:
November 11, 2009 at 11:31 am

As a practice manager / IT of an orthopedic practice in Pennsylvania, I wanted to say thank you for allowing me to provide my opinion on HIT Although there has been an inordinately large amount of discussion and “technical advising” you in both government and IT continue to fail. The technology is here to enable practices to streamline and make simpler the extremely difficult task of making sure that patients are taken care of and followed-up appropriately. Unfortunately this process has been perverted by the do-gooders who continually interfere with administrative rulings and the constant increase in heavy handed oversight by non-medical “officials”. The failure to halt inane, overcomplicated and dictatorial rules is counter to the intent. There is continual pressure to purchase purchase purchase, but nobody not the practices, the IT firms, the Practice management vendors has any confidence that what they are doing now will be acceptable tomorrow. You need to stop worrying about the expert black hats and

concentrate on a set of solid, stable standards that protects us from inadvertent disclosures that is cost effective. Then maintain that standard for x time. This may enable us to reach a positive ROI before you change the standards again and I have to replace what I have with the “new” standard. Again expending resources which could have been better utilized in the care of our patients. As far as I can determine, if I was your boss you would be fired, for failure to perform to expectations. The ideas are all fine and good, but we have to work with the patients, insurance carriers, IT vendors and the physicians.

Sincerely,
George Benyak
AO Orthopedics, Lancaster Pa

Charles Henry, MD says:

www.littlerockeyclinic.com

November 12, 2009 at 2:36 pm

Why Did I Not Purchase a “Traditional” EHR

In 25 years of practice, I have used multiple documentation systems. In 2007, largely because of chart storage issue, our office explored various EHRs. Initial we were looking at “check box” systems but after a meeting with a consultant, grew concerned about their ability to accurately document the results of the examination and to offer clinically useful information. These misgivings aligned with my previous experience:

1. My experience as a consulting physician who feels clinical information buried in 5 pages of exams notes is almost impossible to find. I get as much information from a 2 line “consultation request” as from a multiple page exam record in which I have to pore through “normals” to find the “abnormal” which I need.
2. My brother does Disability Work in Oregon. He complains of the orthopedists with EHR who provide him with pages of legible records which default in so much information as to be almost useless for determining progress.
3. My experience as a faculty member at the VA hospital. They have a highly praised EHR, yet simple requests like “what was the pressure last time?” are difficult to meet, and sometimes require looking for the “shadow” paper chart.
4. My experience as an Intern when I did histories for a private doc. His 5 x 7 handwritten records still set the standard for quick summaries of a patient’s medical history.

5. My experience with my cousin's EHR company in which he offered me the opportunity to develop the Ophthalmology sections, but found that check boxes often didn't provide realistic descriptions of the problems.
6. My experience as a forensic (and quality assurance) reviewer. Traditional records tend to reflect the actual finding of an examination, whereas a finding on "check box" exam is just as likely to be a typographic error.

After considering these issues, my practice decided a "hybrid" system (SRS) offered us the balance between useful, practical records and "pretty" but overly complex records of limited utility.

For me, an EHR must offer a reasonable method of entering data. Check boxes have severe limitations and I don't type so fast. Drawings are critical. Admittedly hand-written record may have legibility issue, but they tend to reflect the actual examination and can be made contemporaneous with the examination. Record storage and transmission is key, but the most critical component is that the old records prove to be both accessible and useful on subsequent visits.

Charles Henry MD
Little Rock Eye Clinic
Arkansas

Anthony Rhodes, MD says:

www.cmortho.com

November 11, 2009 at 3:24 pm

I belong to a 2-person orthopedic practice. I have several quotes for EHR systems. They are all priced at an exorbitant level. Tens of thousands of dollars in hardware and tens of thousands for each of the physicians as well. For larger practices, the incremental cost per physician is relatively small, so for large practices, the price may become "reasonable", but for a small practice, it is a financial hardship. In addition there is a rather large yearly "maintenance" cost, that is also a financial hardship.

Despite statements that EHR will allow us to practice "better" medicine, it is really just another way to keep records. How this will translate into "better medicine" is unproven at best and ludicrous at worst. Certainly it allows bureaucrats to proliferate, but more bureaucrats does not equate to better medicine.

Anthony Rhodes, MD
Suburban Philadelphia, PA region

Jill Lent, Clinical Coordinator says:
November 11, 2009 at 3:13 pm

Having the opportunity to work with both the traditional EMR and more recently the Hybrid EMR, I definitely much prefer the Hybrid EMR functionality. The Hybrid EMR increases productivity, efficiency, patient safety and is very user friendly. Since implementation of the Hybrid EMR in our Orthopedic Specialists office, we can spend more time caring for our patients, sometimes I wonder if anyone remembers that is why were are here. Please give serious consideration to what those of us in the "trenches" are recommending as you move forward with this process.

Jill Lent, Clinical Coordinator
Orthopedic Specialty

George Ellis says:
October 30, 2009 at 12:22 am

I am very unhappy with the requirement that the EHR be digitally entered. This form of entry of data is a significant time waster and impedes the efficient caring of patients. I will have to see several patients less per half day to be able to get the data in correctly. A scanning system does not have this down time and does have significant increases in productivity. I would like the standards to include a scanning modality of EHR/ Thanks for your consideration.

David Richardson, MD says:
www.sqveeye.com
October 30, 2009 at 11:31 am

Prior to becoming an ophthalmologist, I was the CEO of a software development company. Since practicing medicine I have both attempted to develop as well as critically review the available EMR/EHR software. Unfortunately (at least for high-volume practices such as ophthalmology and orthopedics), there is no available EMR/EHR solution that does not slow the doctor down at the most critical time: in the exam room. There appear to be some "hybrid" EMR/EHR solutions (such as SRSsoft) that could meet the clinical demands of an efficient practice. However, these solutions are unlikely to meet the standards yet to be set out by the government. Ultimately, if I choose an EMR/EHR it will be to improve my practice flow, patient care, and reduce expense. **Even a \$44K per physician payment pales in comparison to years of decreased inefficiency.** To choose an EMR/EHR based on certification criteria rather than practice needs (and the two are incompatible at the current time) would be the equivalent of expending more calories chasing a carrot than one could get by eating it.

Based on the current "use" criteria, I would even go so far as to state that it would be worth taking the penalty hit than moving to any of the available non-hybrid EMR/EHR systems. Too bad the government won't certify these systems as they are currently the only ones out there that do not negatively impact "chair time."

Elaine Griffith says:

www.nephrologyofanderson.com

November 11, 2009 at 11:02 am

It is obvious that my four nephrologists will never have the time to meet the requirements as they stand at present, therefore never receiving any of the stimulus money to implement EMR. My concern now is not whether we will use EMR but whether will we be able to use it efficiently and to the extent of not incurring any monetary penalties for our time and money spent. Forced EMR is not in the best interest of the patients. Systems are not ready, requirements are not fine tuned, and physicians are not ready. Penalties for not implementing EMR is dictorial.

Jeff Edelstein, MD says:

www.jpemd.com

October 29, 2009 at 8:13 pm

SRS is outstanding for secure chart access within and outside the office, allows me to customize templates and document what is important to my individual practice. I shudder to think how I would have to 'adapt' to bureaucratic databases that would force me to waste time filling out forms that have no value for my individual practice. Never forget...garbage in = garbage out.

Steven J. Brand, MD says:

November 1, 2009 at 6:22 pm

Our surgical group, Foris Surgical Group, LLP, currently has 4 physicians and had 5 physicians when we implemented a "hybrid" EMR-SRSsoftware's product. Implementation was smooth and integration using an HL-7 interface with our practice management software (MISYS) works well. There is no loss in productivity when using this software so it allows the docs the opportunity to function efficiently—that is, it does not get in the way of patient care.

The template-driven systems that I've seen all try to force a history or physical exam into a "form". It doesn't make sense that a history—the narrative describing a patient's symptoms should be anything but free text. There are many forms of information that we get (fax's, lab tests, endoscopy reports, etc.) where having them inside of a "digital folder" makes them available to everyone in the office (and authorized users remotely) and gives us the ability to forward that information to others as needed.

I urge you to take a closer look at the hybrid EMR systems for certification.

Steven J. Brand, MD

Michele Nanna, MD says:
October 29, 2009 at 9:54 pm

Our practice has been evaluating different vendors. To our dismay we now realize they all fail to fulfill one main objective spelled out by Mr. Obama: the ability to share health information among different providers. While now without an official EHR system, I am able to forward a standard Word document to any of my colleagues, the new system will allow me to forward documents only if my colleagues employ the same EHR system. This will be an enormous expensive disservice to patients, doctors and....taxpayers!

Dan Halpren-Ruder MD PhD says:
www.myurgentmedicalcare.com
November 6, 2009 at 6:37 pm

I am a physician with 25 years of Emergency Medicine practice experience and now 12 years of Urgent Care practice experience (the two areas were worked simultaneously for a few years). I am 62 and started a bit late in practice due to my PhD. I went from the ED to the Urgent Care Center (I own three centers seeing about 70,000 visits annually) because I felt that every physician needs to contribute to the process of bringing cost-efficiency to their practice. As we all know, some 65% of ED patients can be seen in a well-run Urgent Care Center at considerable cost savings. I also have a history of involvement with Quality Assurance, serving on the Board (7 yrs) and as President (3 yrs) of RI's QIO. So it should not come as a surprise to you that I am committed to quality in my practice. Quality in Urgent Care resolves around 4 critical areas: Completeness of Care, Communication with other care givers, being there for the patient, and provider QA.

Several years ago it became clear to me that I would not be able to accomplish progress within these indicators if I remained bogged-down by paper. So last year (pre-stimulus) I committed to transforming my practice. I believe that change is best accomplished as successive approximations, and, **as I had lived through the disastrous implementation of an EMR in one of the EDs I staffed (my productivity crashed from 2.5 pts/hr to 1.5 pts/ hr.)**, I searched for a product that would allow successive approximation. I purchased a product (SRSsoft) that would not interfere with productivity, would allow me to participate in our RHIO, would add E-Rx, and would provide order entry (so that we could win the completeness battle). Be aware that this is not a product that requires provider data input (we still write records). But what it does is allow me to change the way we do business. All of my staff will participate in the change to electronic data. And already, our ability to track patient's work-ups and be complete has improved. So: we change the culture, increase productivity, allow for electronic communication with other providers and pharmacies, improve my ability to provide feedback to my providers, and provide security and access for our records. Having made this transformation, we will then explore how to provide structured digital input – but that is probably 18 months away.

I have to say that this is meaningful use. **If I had purchased an EHR that required digital input from the start, I would have lost productivity and frustrated my staff.** The lesson here is that each provider has to meld their needs to the implementation of an EHR. I was a nerd and so I recognize the Internal Medicine nerds that are running the EHR show. They have worked on it for years and are comfortable with it. But most of us are not that person at all. Please do not try to make a change in 5 years that needs to be successively implemented over perhaps 10 – 15 years. Set achievable goals – the first of which should simply be moving the culture from paper to digital. Practices should be able to electronically communicate with each other. The change should allow QA. Please ask yourselves what you are after: is it the process? If so, allow sequence and time. If you are after data as in PFP or abstractable quality indicators, being impetuous may frustrate all of us.

Greg Caulton says:

www.patientos.com

October 30, 2009 at 1:06 am

Most of the standards published to date have not come close to meeting the average physician offices needs. Privacy, security, insurance, monitoring of their performance do not address their key issues towards purchasing systems that are affordable, usable, enjoyable, or helpful in increasing productivity.

Quite frankly pouring money into ARRA and other incentives is more likely to do more harm as physicians rush out to buy the best system then can find – ending up with purchasing the mediocre but well marketed choices today rather than waiting for the growing industry changers of tomorrow.

Regarding standards and having been involved in the implementation of OpenEHR standards (a work in progress), I believe our direction will be to publish our own Open Source data standard so that implementers can integrate EHR content into our GPL v3 system without the large overhead of the current crop of data standards. Perhaps a practical implementation which is freely available on <http://www.patientos.org> will succeed where other committee based standards have yet to provide meaningful exchange of physician office EMR content.

Jeff Moody, MD says:

www.ppuro.com

October 30, 2009 at 6:08 pm

Several comments: There are over 2000 vendors of practice management software, and 1200+ EMR/EHR vendors. There is not consistency and agreement amongst the experts in the field. Also, we use a small, proprietary EMR very efficiently, but have no real hope of affording the process of CCHIT certification. Also, does making the physician the data entry worker (the slowest and lowest paying job in an office) make sense when by 2025, there will be 200,000+ shortage of health care providers? Just thinking on digital paper.

Linda Holifield says:

www.grouptech.com

October 30, 2009 at 6:06 pm

There is a lot to balance in deciding how to proceed with “meaningful use” definitions.

I wholeheartedly express my objection to there being one single certifying body that charges such high costs for certification that smaller companies with excellent software cannot afford to participate.

On a related note and as reported in the Wall Street Journal, isn't it curious that Senator Grassley has sent a letter to a number of the largest HIT software vendors whose products have been CCHIT '08 certified requesting information as a result of complaints about faulty software? It makes one wonder if certification is really the answer!

Cheenie Pretorius, MD says:

October 31, 2009 at 10:53 am

Hospital implemented EMR and CPOE has resulted in silent but deadly mistakes including mortality, morbidity and more than you can count, near misses. It is reported in the medical literature.

If this equipment (I will not name the vendor nor the hospital for retaliation has been administered for issuing complaints) was another type of device, eg knee joint or defibrillator, and caused such risk, it would undergo a Class 1 recall and be removed from the market place.

I suggest you check in with Senator Grassley for the list of complaints and go to the FDA database.

You will not get accurate reports by using this method. Do you think that doctors are going to post their unexpected deaths caused by this equipment in a public forum?

Charles Henry, MD says:

www.littlerockeyeclinic.com

November 2, 2009 at 11:11 am

1) For years I have consulted in the VAH system. As for the highly touted EMS, HA!. I can't tell you the number of times I have asked about a finding on the last visit only to watch the resident flail around trying to find a simple bit of information. In some instances, a “shadow chart” is kept so that information is readily available.

2) Our 9 doctor ophthalmology practice moved to a hybrid systems (SRS) 4 years ago. We expected a significant loss of productivity and resistance from older doctors. Six weeks into the process a paper record was handed to a senior doc who looked at it, handed it back and said, ‘Scan this for me, it is easier to use that way”

3) The goal is to “communicate”, not just be connected. When I get a typical 5 page computer EHR, I have to spend 10 minutes trying to find the one bit of significant data that wasn’t defaulted it.

4) Medicine’s agreement to the current payment system is partially to blame. Paying by the “number of boxes checked” only assures that lots of boxes are checked, clogging the system. “No change since last” isn’t so bad.

5) Is this webpage managed by someone who has responsibility for new EHRs? Is it my imagination, or is it misinstalled so that you can only Agree-Disagree once on the page, not once per post.

Douglas Shepard says:

October 30, 2009 at 1:08 pm

I use a computerized voice recognition system superimposed upon my custom built templates, store electronically, and e-fax the report. Also, do e-prescribing. For a specialist, point and click is folly.

Skeptic says:

October 31, 2009 at 11:53 am

The need for standards seems to be oriented towards a medical system where patients are moved around from doctor to doctor against their will, as in – socialized medicine.

When patients move themselves voluntarily, they can bring their records with them on paper, and a new practitioner can backload what they need into the new EHR.

The fictional scenario of showing up unconscious at some distant medical center, alone and without ID and contact information, and needing instant treatment that solely depends on an EHR (not on physician judgment) is so rare as to be nil.

In summary, there is no substantial benefit to patients of “standards”, only to payers and government regulators. It would be a lot cheaper to deliver paper records by FedEx than build a “national interoperable health IT system” at a cost of tens or hundreds of billions of dollars. Give that money to the poor so they can get care.

Elimination of the \$\$\$ spent on all this would also allow hospitals to counterbalance Medicare cuts and remain economically viable.

Kate Galambos, RN, MSN, CPHIMS says:
November 1, 2009 at 9:02 am

No matter what EMR product (or hybrid) is being implemented, certain conditions must exist. Without these conditions in place, the EMR will never succeed and meaningful use never attained. The fundamental conditions for achieving meaningful use are:

1. Stable, reliable technical infrastructure with 100% uptime
2. Standards-based vocabularies AND data entry into discrete data fields (i.e. no text entry of critical information such as diagnoses, allergies, or medications)
3. Achievement of 80% utilization with an on-going plan to reach 100% within a reasonable time frame: (80% Rule=80% of providers use EMR all of the time AND/OR 80% of patient charts are 100% electronic)
4. Organizational leadership and change management support for technology-enabled process redesign.
5. Data obtained from the EMR are directly used to improve provider performance and patient outcomes

These conditions are difficult to achieve, but without them there can be no success. Physicians need support at this basic level! Pie-in-the-sky proclamations about quality, consistency, and interoperability are far removed from the challenges of implementation at the level of the medical practice.

Finally, usability remains a huge challenge. Older applications are woefully inadequate compared with facile newer technology. It has been said that asking a physician to use an EMR can be like forcing them to write charts with their non-dominant hand. Would you submit happily to such a requirement?

Lyle Berkowitz, MD says:
www.drlyle.com
November 3, 2009 at 10:16 am

My perspective comes as a practicing PCP (Internist) who has used an EMR since 2002, as Medical Director of Clinical Information Systems for a large primary care group, as a past Medical Director for an EMR company, and active consultant in the EMR space.

I'm all for using EMRs meaningfully, and second, I'm all for rewarding physicians! However, **I believe (as many do) that our current crop of EMRs are far from perfect and I have to question whether we could spend that \$36 billion a better way than by rewarding mediocre vendors whose products are poorly**

adopted and poorly used (see the National Research Council's recent report: http://books.nap.edu/openbook.php?record_id=12572&page=R1). Rather, for a fraction of that money, perhaps we should consider creating a national EMR framework upon which vendors could build their applications (yes- sort of like the iPhone). This then solves interoperability immediately, and lets the vendor compete on applications and user interfaces rather than on all wasting time/money trying to replicate databases which limit their ability and creativity in building what we really need. More thoughts on this topic: <http://www.modernhealthcare.com/apps/pbcs.dll/article?AID=/20090430/REG/304309994/1029&nocache=1#>

However, if we do keep the current definitions of Meaningful Use, then my three main talking points would be:

1. E-Prescribing: make this definition broad enough to reward providers who use their EMR to create and print out scripts, don't limit to just electronic transmission to the pharmacies, as that is not yet a perfect science.
2. Interoperability: reward based on ability to share data in a group or with a hospital, but don't require regional or national sharing at this point, that is way beyond the means of most providers and vendors.
3. Data reporting: reward based on producing the reports, whether from the EMR, an EDW (Enterprise Data Warehouse) or similar. Most EMRs are bad at report writing, and other tools are needed.

More details on all three at:

<http://www.histalkpractice.com/2009/08/25/dryles-meaningful-discussion-about-meaningful-use-82609/>

Oliver J Lawless MD says:
November 1, 2009 at 10:38 pm

EMR are tools and only work in the presence of a meaningful intervention strategy to reduce risk and improve outcomes of the high morbidity, high mortality hi cost diseases. It has been estimated that we spend \$6000 per cap per year on healthcare. A streamlined plan to assess those at risk (population wide) and intervene early, using the appropriate tools we now have available, would change the face of medicine, by reducing the risks identified, improving the outcomes, and reducing the cost. It is a doctor-patient contract, and can be sponsored and funded by the government, but not employed or advanced without recognition of this fact. All outside of this contract have been parasitic on it for years. Thus, hospitals, pharmacies, insurances, and pharmas should all be presented with such a plan, but it must go through the physician/patient contractual obligation."

Philip Nelson says:

www.pai.com

November 3, 2009 at 10:32 am

Reading through the discussion it seems like a few important themes are here.

- Doctors and nurses hate EMR systems. Productivity loss due to data entry time may offset any other gains improvements health IT could provide

- Researchers, data aggregators, payers and policy makers need quantifiable facts that only providers can provide. For any hope of efficiency gains through health IT, this is step one.

This seems ripe for innovation. Listening to the frantic views of providers worried about productivity it seems that few EMR vendors have found ways to fit into their practices. A view of health IT as forms, data and reports may be a poor model. Perhaps the idea of domain specific languages (computer readable mini languages) could help. I seem to remember seeing charting by my nurse wife which had more structure and nomenclature than plain old English. Could some of this be parsed for data extraction? Are there other types of notations that would be more useful?

Even if these approaches aren't possible, we are still talking about solving one key problem, transcribing notes into quantifiable facts. **Some parts can happen at the point of entry but it should not add cost to the system by lowering productivity of the caregiver.** This transcription doesn't have to be done by the doctor or caregiver. It probably doesn't have to happen immediately and not even at the doctor's office. Some parts could be automated, others not and it may vary widely by specialty.

Understanding that would seem to say that health IT standards should not be deeply invested in vocabularies and structured data. Instead it should be more about extensible document exchange with vocabularies limited to some pretty basic health concepts. This is consistent with much of the testimony in the conference, but not with how people describe the EMR systems' role in the current system.

Robert Wilson says:

www.crozer.org

November 4, 2009 at 2:51 pm

I am very excited about the proposed initiatives on electronic health records as a means of improving patient safety and quality outcomes, decreasing patient and provider cost which will ultimately lower cost to the government supported programs and commercial insurers. I believe the journey will be very difficult for all parties and will not be completed in the time frames now being proposed and will require more funding than expected. I also believe these are concerns we should all accept and acknowledge and this should not cause us to "pause" or

“hesitate” in moving these important programs forward. However, I do believe we are making serious errors in the path we are outlining to the provider community to follow in order to obtain electronic health records. Specifically, all the information and data that I have read regarding providers who have successfully (and those that have failed and acknowledge mistakes) implemented CPOE systems are clear that several foundation system installations are required BEFORE implementing CPOE. These systems are Clinical Electronic Nursing Documentation and vendor integration of the CPOE system and the Pharmacy system. Although, I’m sure there are institutions that have not implemented these foundation systems and managed to complete their installs with relative success, the data suggests that this is not the preferred order. If we marry the accelerated implementation plan that is proposed (I believe we can all agree the plan is aggressive) and combine this with an implementation plan that omits Clinical Electronic Nursing Documentation and the integration of CPOE and Pharmacy system, I fear we are engineering a flawed path for our providers. In the end failed installations could result in more clinical errors to our patients than we have today, delayed implementations, increased funding and a significant disruption to the clinical community (Doctors and Nurses). I trust these comments will be received in the manner which they are intended as a concerned and supportive receiver and provider of health care.

Regards,
Bob

Leon A. Bynoe, M.D. says:

www.retinasurgeon.net

November 9, 2009 at 3:56 pm

Financial disclosure: I have no financial interest in any product discussed below.

Implementation is the biggest hurdle medical practices confront when converting to EHR; in fact many practices fail to implement and lose significant time and money during this often unnecessarily painful process. However, implementation of EHR can be literally painless if:

1. A “document-centered” EHR platform is employed (as opposed to “data-centered” EHR); and
2. Implementation is performed in 2 stages:
 - a. Immediate conversion from paper documents to a fully “paperless” office; followed by
 - b. Conversion of the “paperless” office to fully digital data at a pace that is comfortable for the physician(s).

That was the approach I took when I opened my practice in August 2004, and I am convinced it would work well for any practice of any size as it causes little or no drop in office production during implementation AND would allow a significant INCREASE in production once fully implemented.

There are 2 general types of EHR – “document-centered” and “data-centered”. Most EHRs are “data-centered” and require practices to adapt to templates designed by the software producers. As physicians may think quite differently than the template designers and consultants, this often leads to implementation resistance and/or failure.

However, “document-centered” EHR allows physicians to go “paperless” without having to adopt someone else’s template. One’s own current office exam forms and documents can be scanned into the EHR as custom templates and the physicians continue to fill out their forms, except instead of using pen and paper, the physician writes onto the screen of tablet computers.

Furthermore, “document-centered” EHR such as the one I use are set up just like the Windows and Mac OS environments we’re all used to – folders, “drag and drop”, “cut and paste”, etc. So most people find themselves immediately familiar with the form and function of a “document-centered” EHR because if they’ve ever used a computer, they’ve seen and have performed these same maneuvers before.

Finally, “document-centered” EHR has the same feel as paper charts and can be organized the same way. In “document-centered” EHR, charts can be subdivided into various folders which group similar documents together (like initial consults, follow-up exams, consent forms, operative reports, letters to referring physicians, etc.). It is very much like one’s current paper charts, except these electronic charts do not need to be physically filed or pulled, they are NEVER lost or misfiled, they can be IMMEDIATELY accessed from anywhere (such as from your home or satellite offices), and they require no paper or ink. Furthermore, the value of automatic and instantaneous transfer of data to any template or document you wish cannot be overstated (for example, dates of service and patient demographic information can be automatically placed on any template upon opening it; no one has to type or print this manually)

Of course, the ultimate goal is not to simply have a “paperless” office, but for the EHR to be comprised of fully transferable digital data. When one writes on a tablet computer, the writing is really an image, not data. (For example, if I write a visual acuity as “20/20” my writing is only an image of “20/20”, not the actual 20/20 data). Therefore, physicians will want to change their EHR from simple “image templates” that look like your current exam forms, consent forms, etc. to make the best use of the data features of EHR (for example to keep track of data like visual acuity). This will allow the transfer of such stored data anywhere you like (such as having the visual acuity from the last visit automatically entered on follow-up forms), and that requires the use of data objects, such as text boxes, number objects, and drop-down menus. Entering data this way can be a little more tedious than simply writing on a tablet computer – but not by much and one very quickly get used to it. However, the benefits are ENORMOUS. You cannot measure how much it helps to have the numeric data or clinical descriptions from a patient’s previous examination automatically displayed in the same location you will be entering the current findings. And if the finding hasn’t changed, you simply don’t have to enter anything!

The great thing about “document-centered” EHR is that it allows the physician to go “paperless” very quickly and painlessly and then to convert their custom “paperless” platform at one’s own pace to fully digital data EHR whose templates are customized by the user(s). This approach is far less problematic than trying to go directly from a paper chart-based office to digital templates designed by someone else. Right now my templates are almost entirely data (except for the sections for retinal drawings). Because I gradually added the data objects myself, my office functions were never negatively affected as I’m sure they would have been had I started with a “data-centered” EHR with templates designed by someone else.

It is my hope that the issue of implementation is given strong consideration when EHR certification standards are set.

j says:

November 5, 2009 at 7:00 am

While I applaud that steps are finally being taken to improve healthcare outcomes and reduce cost via technology, I cannot help but wonder if the mandated steps required are somewhat out of order. For instance CPOE requires basic building blocks to be in place to ensure that all clinical data relating to the patient encounter is taken into consideration before an intervention is planned or acted upon. Without Closed Loop Medication Checking in place, the physician only knows that the patient has been previously prescribed a medication but not that the patient received it or when. How then can the physician make effective clinical decisions without even knowing what information from the patient’s chart (electronic nurse charting) or medications the patient has taken if it is not fed into the CPOE product? The same is true for things like meals or other ancillary data the provider CPEO application may not yet be capturing.

Additionally, while I have always been pro EHR and argue for the benefit of such a system, unless the US moves to a single nationwide patient identification system much like the European health cards, EHR data is likely to be silo’ed and regional at best. How does that help a patient that may need emergent care in another region of the US while on business or vacation? For EHR data to be truly valuable and effective it must be easily and speedily accessible by any provider treating the patient. This has been one of the drivers behind PHR products from companies like Google or Microsoft.

It would seem that if we are to throw billions of dollars at healthcare technology quality outcomes should be better defined and it left up to the individual providers on how to deliver that outcome. In line with that a EHR model should be national either via interconnectivity of providers or via a national clearing house. Also to capture the whole continuity of care spectrum it will need to include all private physicians, public health delivery providers, and all (not make it optional) providers.

Sam Winebaum says:
November 9, 2009 at 10:42 am

Thank you very much for inviting comments in such an open way. I have read with interest the several comments from users of "hybrid" systems as well as the other valuable input

80% of physicians use dictation to prepare at least part of their documentation.

There are three main reasons for this preference for voice:

1. Voice dictation is the most time efficient method, especially important for specialists seeing 40 or more patients a day in clinic. A <2 minute dictation vs. average 5 minutes to document with a point and click system adds up to a huge difference in daily workload. A bit more than an hour to dictate a day's work vs. potentially 3 hours or more with a conventional EMR.

Where will the additional time to generate data come from? Longer hours, hiring scribes (see October 7th USA today) to enter data, fewer patients seen, less data entered?. Even with the incentives in ARRA will this type of practice chose an EMR or continue to dictate @ \$1000-\$1400 per month per physician? Not to speak of the issues of most hospital based dictations only marginally interrelated to the rest of the record.

2. Voice dictation is convenient and portable but not always HIPPA compliant as it can be done anywhere.
3. Use of speech is more flexible as to language and better able to express the particulars and nuances of a case yet the results of free form dictation can be lacking in structure ,required items and most importantly usable data. Further, decision support, drug interaction, ordering, etc... are problematic as they are not linked to the encounter documentation and notes.

Without innovative solutions which maintain productivity and flexibility many specialists who are for the most part independent business people, not employed in networks, will continue to dictate as the productivity hit when combined with the expense of a conventional EMR system may not even make the \$44K incentives worth it to go fully electronic, selecting instead "hybrid" document management systems as others here have posted.

The big issue with dictation and transcription, or for that matter real time speech recognition as a substitute, is that documents are in most cases, essentially a "digital" piece of paper readable by humans but not computable in any meaningful way. The requirement for HL7 CDA and Snomed in Meaningful Use, initially a header and document image for many, is a big step in the right direction as it will help eliminate the costly and dangerous shuffling of paper between providers, eliminate duplicate testing and data entry. A deeper use of XML based

clinical documentation allows standards based tagging of language to extract the clinical facts and provide decision support. A bold and correct move in the right direction.

What are potential solutions which are incrementally move users to an electronic record yet maintain productivity and flexibility and generate usable data such as outcomes data for evaluating the effectiveness of medical devices or easily shared clinical summaries? Not conventional "document management solutions" as while they digitize the paper these systems they do not inherently make the content computable or more consistent in terms of completeness.

While conventional EMR's are able to manage and can be productive in primary care environments or integrated networks where a team cares for a given patient they are ill suited to the needs of specialists and working a computer instead of focusing on a patient during a visit can squander the precious face to face between physician and patient.

We see as part of the solution, and have been working on and can demonstrate, a different kind of hybrid EMR which is entirely web based and bridges the productivity and flexibility gap between the "speed" of dictation and a traditional structured EMR. The approach has as its key values usability, flexibility, and contextual content. A highly modular architecture would allow the entire community of physicians, payers, and other vendors to provide (free or paid) subscription based modules to suit clinical and business needs.

The data format and structure are XML based on HL7 CDA from start of visit and templates to stored information. Such an approach, when combined with standards based tagging of content, generates reusable reportable data without forcing physicians down "fixed" paths. We think a XML document centric approach provides flexibility yet data richness and removes the legacy translations and complexities which most EMR's face in moving towards the goals of a truly interoperable national healthcare data network.

Voice, touch, click can be used for command and control and data entry. The documentation "template" is neither static or free form but part of a dynamic, highly contextual interface which brings historical information, coding choices, decision support, documents and tools into view as needed or requested using system intelligence and user, clinic and more general (such as the ARRA reporting requirements) best practices.

A user can dictate into standard sections arranged to suit the case and requirements, with the narrative tagged for clinical facts via Snomed and evaluated for compliance via NLP. Users can pick standard findings in context of the problems being evaluated, using language to expand on them. They can also use no additional cost real time speech recognition to eliminate or reduce their transcription expense. They can talk, type, touch or pick any modality at any time to suit their style and also workload of the moment.

As an entirely web based system with modules subscribed to a la carte costs to adopt and use will be low and productivity will remain high during the transition

and ongoing use. Data will be rich, contextually accessible and share able meeting or exceeding Meaningful Use requirements.

We believe such an approach will lead to actual "operational usability" for all physician work styles and levels of technology comfort others have posted about here.

Massoud Alibakhsh says:

www.nuesoft.com

November 10, 2009 at 12:40 pm

As the CEO of a health information technology company, I commend the government's objective to increase EHR adoption, but take issue with the approach. Health IT models are still relatively young, and we will benefit more in the long run by concentrating now on innovation in the field, rather than mandating that health IT systems conform to standards and can perform certain functional criteria. Some doctors may be moved to implement EHRs through HITECH's incentive and penalty program, but many, many more (including a few who have posted their thoughts on this blog) will no doubt be inclined to implement a tool that will truly support their workflow in a realistic fashion. Do we really know what that tool looks like yet? Why not first gain a better understanding of the technology models that are most effective – and most conducive to meeting HHS' goals of interoperability, privacy, security and cost savings? I contend that a true natural process for the emergence of adaptive and successful solutions is evolutionary in nature. This process is only effective if the variations on automation tools increase — and are not artificially limited by — some biased certification program as we have had in the past. And only the end users in the marketplace, namely the physicians, can truly decide what works and what doesn't (natural selection). The government as a central player can have a progressive impact if, and only if, its actions are aligned with this process. We would be better served spending a portion of the entire \$19 billion allocated for HITECH funding on the research and development of code, templates and engines, and then using those to create a transferable technology that is readily accessible in the public domain. There's a precedent for this within government, by the way: DoD's DARPA program, which eventually gave us a public network (the Internet), and used the marketplace, rather than legislation and regulations, as a conduit for widespread adoption.

Unfortunately, I fear the incentives and disincentives may rush the marketplace into a wholesale adoption of existing solutions, most of which were cobbled together in the last century using outdated technologies by today's Internet standards. The widespread implementation of such systems would have serious implications and most of them will be negative and can potentially mean a step backwards. Aside from their potential negative impact on workflow issues, the ongoing security of client/server based technologies will be virtually cost prohibitive. Can you imagine every physician's office with a server and a database loaded with your health data and a connection to the Internet? The hackers all over the world will have a field day! Far from progress and savings in healthcare, that's what I would consider a doomsday scenario!

Kris says:

November 11, 2009 at 10:58 am

Our solo Ortho office has been using EMR for two years with (relative) success. **Implementation was long and painful** – I would estimate one year to comfort. It has caused some cost savings and overall increased productivity somewhat. The software is CHIT certified. I caution you that there is no magic bullet contained within. It is still a medical practice with real live messy situations and it is still a paper pushing machine albeit a digital one.

There is one item that I mention as a possible improvement that would probably require some legislation to fix – RE: E-Prescribing. A large number of our scripts are not permitted to go electronically due to regulations in place that prohibit any of the narcotic class to be prescribed except on paper (or faxed) . If that could be fixed, we would be able to send all E-RX.

David Tao says:

November 11, 2009 at 5:25 pm

HELPING THE LITTLE GUY!

I applaud the Implementation and Adoption Committee's recognition of the need to help the "little guys" (both providers and vendors) get interoperability working across all types of practices, comprehensive EHRs, small modular or hybrid EHRs, PHRs, and other systems, for the good of patients and their families.

But how should we do this?

Let's look at the "forest" not just one "tree." The big issues for the "little guy" are the sheer volume of requirements, standards and specs that are proposed, from clinical exchange to quality reporting to population health to security, privacy, and infrastructure. It's hard enough for "BIG guys" to absorb all that, but at least they're more likely to have "standards geeks" who can focus on it, unlike small organizations. So why not help EVERYONE out with a "less is more" approach by CLARIFYING requirements, FOCUSING on fewer fronts, and SIMPLIFYING by reducing layers of documentation and providing free open access to tools and resources?

CLARIFY! Ambiguity can lead to huge amounts of wasted time speculating, guessing, interpreting, and paralysis due to uncertainty. When hundreds of organizations are asking question like:

- Which of the multitude of standards incorporated into six HITSP capabilities apply to which of the six Subject Areas (cells D8 and E8 of the Clinical Operations matrix)?
- Do I have to encrypt the data 'at rest' inside my organization?
- What is the quality measure for prescribing generic drugs and how can I possibly get it done in time if it's unspecified?

FOCUS! Just reading the dozens of standards, let alone implementing them, is MUCH more likely (than any choice of one standard vs. another) to overwhelm “little guys.” Why not focus on a small but pivotal set of standards that are NOT ambiguous and just need to be implemented across the board? Why aren’t unspecified measures just taken “off the table” for 2011 rather than keeping everyone in suspense for months?

SIMPLIFY! The current set of standards, implementation guides, and interoperability specs scattered across many organizations, with many layers of documentation, and licensing/access restrictions, is daunting, as has been stated often in the HIT Standards Committee. Integrated publishing and views that consolidate ALL the required information in one easy-to-read presentation could help everyone.

Clarifying, focusing, and simplifying are hard work, and I appreciate many dedicated volunteers who are trying to do it. I suggest a “full court press” on this issue, with the full backing of ONC (since this certainly entails a “coordination” effort). The results will help thousands of developers and implementers and millions of patients to the extent that interoperability is facilitated. As Mr. Spock said, “The needs of the many outweigh the needs of the few.”

Hadley Callaway says:

www.raleighortho.com

November 13, 2009 at 4:22 pm

I went into orthopedics because the specialty treats patients of all ages with a diverse group of problems. We do trauma, congenital deformities, systemic diseases like lupus and RA, sports injuries, dislocations, arthritis, spinal deformities, and more. We have operations that involve almost every part of the body.

Orthopedics is incredibly diverse and completely different from other medical specialties. For that reason, it needs an orthopedic-specific EMR. And the definition for “meaningful use” should be different for orthopedics than it is for other specialties.

Meaningful use for orthopedics should include:

1. Ability to manage images (xrays, MRIs, arthroscopy images, etc.), including making the images accessible to outside providers and having the ability to easily acquire outside images.
2. Full participation in electronic prescribing and medication reconciliation.
3. Full participation in national registries for implanted medical devices.
4. Making available to other providers a narrative record of the orthopedic evaluation and treatment plan.

5. Ability to fetch, meaningfully display and manipulate all the data made available by other healthcare providers over the network.

Meaningful use for orthopedics should not include:

1. Structured data which is highly observer-dependent such as range-of-motion measurements, amount of swelling, etc. This type of data is “garbage in, garbage out.”
2. Templated notes which are very difficult to interpret and mainly designed to achieve higher levels reimbursement. Some providers send us 3 page notes which are obviously computer-generated templates and yield very little meaningful information. We look at the bottom to the free-text area to see what really happened during the encounter.

I believe that someday there will be a perfect orthopedic EMR software. It will have a different data entry form for each ICD-9 code, perhaps depending also on the age of the patient. For post-operative patients there will be different data entry forms for each procedure CPT code or combination of codes, with one for early and one for late post-op visits. When that day comes, the definition of meaningful use for orthopedics should include the structured data elements. Until then please do not penalize orthopedic surgeons for not using a product that doesn't exist.

If meaningful use for orthopedic surgery is developed with the five points that I suggest above, the \$40,000 federal stimulus will be sufficient reward to move the specialty into the digital age. The ability to exchange images will improve care and eliminate needless duplication of expensive studies. The electronic prescribing will save lives and reduce narcotic abuse. The participation of orthopedic surgeons in national device registries will identify inferior devices and treatments. And the exchange of office records will improve medical care coordination dramatically.

Please do not force orthopedic surgery into the one-size-fits-all meaningful use requirement. Look at each specialty separately, decide how that specialty could contribute to the improvement of healthcare through information sharing, and design the meaningful use requirement for that specialty accordingly.

How will you prevent physicians from claiming their stimulus under the specialty program with the least-stringent meaningful use requirement? Require them to submit a copy of their board certification for the specialty. Medicare may have other means of classifying physician specialties. Do not rely on self-designation or the AMA Masterfile.

Thanks for considering my suggestions.

Hadley Callaway, MD
Raleigh Orthopaedic Clinic
Past President, North Carolina Medical Society