A "KISS" EMR May Be All You Need

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The Obama Administration has continued where the previous one left off in advocating the widespread adoption of electronic (digital) medical records (EMRs). But an expensive EMR system loaded with bells and whistles that you don't really need, and requiring doctors to interact with computers, can cost you in terms of patient-care time as well as money. The Big Three elements of a practical EMR system are electronic visit notes (which can encompass dictation/transcription), drug prescribing, and lab test ordering/results. An inexpensive "KISS" (Keep It Simple, Stupid) EMR containing these basic elements, and not requiring disruptive changes in office routines, may be all you really need.

Key words: EMR; visit notes; electronic prescribing; CCHIT.

The Obama Administration has continued where the previous one left off in advocating the widespread adoption of electronic (digital) medical records (EMRs). But there has been no such edict as, "Thou shalt be required to implement a very expensive EMR loaded with bells and whistles that you don't really need." Sometimes less can be more.

Let's not take our eyes off the ultimate goal of the policy, which is not to burden medical practices with unwieldy EMR systems, but simply to have the basic health record in an electronic format that is easily accessible by any healthcare provider who needs it. This will help to provide patient care in a more efficient manner with less chance for error due to miscommunication.

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It seems that in October 2011, Uncle Sam will begin allocating billions (with a "B") of dollars in "Stimulus" money to help ensure that records become electronic within five years and that healthcare information technology (HIT) is utilized "in a meaningful way" (a phrase, from the legislation's wording, whose meaning is open to interpretation). Earlier this year, the federal government's 21-member HIT Standards Committee held a hearing on Meaningful Use.

Writing on May 12 in his "Straight Talk" blog, SRSsoft CEO Evan Steele noted that during the hearing, Dr. David Classen from the University of Utah cited a study revealing that a number of EMRs already certified by the Certification Commission for Healthcare Information Technology (CCHIT; see below) "did not fare very well in meeting several test measures of improvement in quality of care."[1]

The point was also made that an EMR needs to be functionally usable not only by primary care physicians (the providers around whom the "meaningful use" discussion continues to be based), but also by high-volume specialists who have less time, if any, to spend inputting data into a computer.

Those points seemed to come as news to the 21 committee members, none of whom represents high-volume doctors or alternative EMR technologies. And citing a recent study in *Medical Economics* in his April 29 entry, Steele points out that allowing an EMR to automate E/M coding "has led to severe financial and legal repercussions for practices" in that it "raises a red flag with payers, and EMR documentation does not stand up well in the resulting audits."[2] Patient visit notes need to be sufficiently comprehensive, and EMR-templated notes are often lacking.

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To put it bluntly, the government's emphasis on big, traditional, template-driven EMRs as a one-size-fits-all solution is naive. And there are additional stumbling blocks to establishing a universal system for converting to EMRs and allowing records to be seamlessly moved around. Some of these are:

1. Privacy concerns
2. Financial considerations
3. Disruption to office operations
4. Finding easy and secure methods of transporting of records
5. Government interference in the process

I would like to address these issues one by one, suggesting solutions to these dilemmas, and in conclusion provide a blueprint for moving forward while minimizing the burden of doing so.

PRIVACY

Privacy concerns are of paramount importance. As health records are transmitted around the world, every precaution must be taken to keep them from falling into the wrong hands. It does puzzle me, though, as to why this has become such an up-front-and-center issue with the advent of electronic records, while it has been considerably less so with the "paper" system. Electronically, the additional privacy risk is pretty much limited to the need to protect against hackers. But the paper system can be "hacked" much more easily than the electronic system, since it would be just a matter of surreptitiously making one's way into an office and photocopying from the chart. An employee of the doctor's office, a maintenance person, or anyone with access to the office can make copies of records, or scan the records and e-mail them anywhere.

My point is, if someone wants the records badly enough, that individual can get them. No worldwide EMR network can be created with 100% security (hackers have even violated the Pentagon). The current method of rendering records unreadable to unintended recipients is to encrypt the files on the sending end and decrypt them on the receiving end. With the aid of virtual private networks (VPNs) and file transfer protocols (FTPs), both of which are commonly used technologies, keeping records safe from forbidden hands is made all the easier.

FINANCES

Financial considerations are obviously going to play a significant role in any medical practice's decision to move forward with implementing an EMR system. If you believe that all you will need to do is tell the federal government that you want to purchase an expensive EMR system, and that shortly thereafter a Stimulus check will be forthcoming in the mail, then I have some swampland here in Florida to sell you. I am already reading that to qualify for Stimulus money, you may be required to buy a system that is sanctioned by the CCHIT, which may not even include some EMRs currently in use, no matter how suitable they might be. If I read the CCHIT price list correctly, certification will cost the EMR company close to $150,000, guaranteeing that the "big boys" will have a monopoly on access to the certification process and virtually eliminating entrepreneurs with products that are simpler, more practical, and less expensive.

Certainly the federal government needs to be confident that basic standards are met when it allocates money for HIT, but its onerous bureaucracy may defeat the purpose. Solo and small group practices, and perhaps even larger clinics that don't enjoy wasting time and money wading through bureaucratic red tape, may thus opt out of the Stimulus/CCHIT program altogether and absorb the out-of-pocket costs of an inexpensive system that meets their needs.

DISRUPTIONS

Disruption to office operations really comes back to financial considerations. I am familiar with a 50-doctor multispecialty clinic that adopted an EMR system and forced providers to completely change their daily routines. The doctors were told to interact with their computers, use templates, etc. That formerly 50-doctor clinic is now a 39-doctor clinic, and according to its currently unemployed prior administrator, it is now having serious financial difficulties. I believe that the desired goal can be accomplished without forcing such changes to the daily routine of providers and the office's day-to-day operations.

TRANSPORTING RECORDS

A method of easy and secure transporting of records from one place to another currently exists. As previously mentioned, encryption, FTP, and VPN processes are already common practice. And there is already an industry-standard protocol for two-way communication between facilities, called Health Level 7 (HL7). HL7 is the good news. The bad news is that HL7 interfaces between two facilities must be uniquely fine tuned, often involving the need for extended back-and-forth test transmissions, and often negotiations between the two parties as to the cost of creating the "inputs" and "outputs."

I have witnessed this process many times over the last few years, and the cost from an EMR company to its clients for establishing those connections has been as much as $25,000 per interface, and in many cases two interfaces are required, one to send information into the EMR and another to retrieve information from the EMR.

GOVERNMENT INTERFERENCE

Government interference in the process will be an ongoing concern, as the feds are riding this horse very hard. Government bureaucrats are anathema to the KISS (Keep It Simple, Stupid) concept. They are involving groups like CCHIT (mentioned above) and others to try to make up for their lack of understanding of the total picture. And I suspect they will make it very difficult to qualify for the Stimulus money.

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In my opinion, in order to satisfy the government's requirement that HIT be used "in a meaningful way," the following elements are the Big Three:

1. **An electronic record of the patient encounter with the provider.** The visit notes comprise the basic elements of the medical record. It has been estimated that the notes of the encounters between the provider and the patient contain 70% of the patient information and are the basis for the coding to get paid. As alluded to earlier, templating just doesn't cut it. If the patient's visits are documented thoroughly in these notes, they will contain most of the essential medical information on the patient, including medical history, physical examination findings, lab and other test results, diagnoses, prescribed drugs and other treatments, etc.
2. **Electronic prescribing of medications.** Words scribbled on a prescription pad in undecipherable handwriting has for years been fodder for comedians. But it is no joking matter when an incorrect medication is dispensed from the pharmacy as a result. In its most rudimentary form, an e-prescribing system could render a legible prescription from a printer. Ideally, it would be interconnected with area pharmacies and transmit the prescription via HL7 or some secure mechanism rather than a piece of paper.
3. **Electronically ordering laboratory tests and receiving the results.** Having a two-way HL7 link with your reference laboratories would eliminate the need to manually scan or otherwise input lab results into the patient's electronic record. And though it may be easy enough to fill in the check-boxes on a lab requisition, electronic ordering not only could automatically populate the patient's demographics (as well as the requested tests), it could also, if linked to the patient's insurance information, assure that the lab work gets sent to the correct lab. Too often a patient is sent to "Lab A" for a blood test, etc., only to find out too late that the insurance company will not cover the cost of the test because its clients must use "Lab B." In addition to the electronic order, a facsimile paper requisition can also be generated for the patient to take to the lab.

Now for my idea of a practical EMR solution involving minimal cost and very little disruption to your practice: Assuming that your preference is to avoid the pitfalls that befell the 50-doctor clinic discussed earlier, you might desire a relationship with a password-protected, Web-based medical transcription company with full VPN, FTP, and HL7 capabilities. That company should archive your records permanently and offer easy search capability. In addition, your page on the transcription company's Web site ideally should provide you with the ability to e-prescribe as well as order tests from your reference labs and access the results, all of which would be linked with the patient record.

As simple as it seems, this solution offers you the three main components of an EMR at very little additional cost beyond that for your normal transcription. The records and capabilities are maintained on one Web site for easy access, and your providers can continue to interact with their patients with little or no disruption of their daily routines. Instead of waiting until October 2011 to apply for Stimulus money to help defray the cost of implementing an expensive EMR that requires routines to change significantly, and results in seeing fewer patients and generating less revenue, it may be more practical to go with a simpler solution now.

Then, if at some future point you wish to transition to a full-blown EMR, all of your digital records can be easily imported into any system you might choose, as opposed to having to scan in non-digital records, which can be costly as well as cumbersome. Perhaps the federal bureaucracy, in its infinite wisdom, will someday even come to appreciate the beauty of a "KISS" EMR and ultimately agree that a simple solution, such as described herein, is all you really need. ■

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