A vision of tomorrow: Honoring patient choice

BY RICHARD A. SZUCS, MD

Richard A. Szucs, MD, is a radiologist with Commonwealth Radiology, P.C., and president of the Board of Trustees of the Richmond Academy of Medicine.

STARTING A CONVERSATION ABOUT end-of-life care can be difficult, whether we are physicians, patients, family members, religious and community leaders or other professionals. It is, however, imperative that these conversations take place. And, once they occur, it is equally critical that caregivers honor patients’ choices. When no conversation occurs, families and caregivers are left making decisions that may not reflect what a patient desires.

The Richmond Academy of Medicine champions advance care planning, hospice and palliative care. Within the last two years, we have developed a core group of healthcare professionals, including hospice and palliative care specialists from Bon Secours, HCA and VCU, to advise us regarding how we, working with others, can promote and encourage advance care planning (ACP) in this community. The core group agreed that adopting a uniform approach to ACP across the healthcare marketplace was essential for increasing awareness and engagement.

In late May 2013, the Academy sponsored a community-wide educational conference where 100 healthcare professionals from the health systems and the wider community came together to learn about best advance care planning practices. There was unanimous support among the participants that the Richmond Academy of Medicine assume a leadership role as catalyst, convener and organizer of a community-wide effort on advance care planning. Everyone agrees that advance care planning is a lifelong process, best begun before a crisis develops.

We shared the outcomes of the conference with health systems, Secretary of Health and Human Resources Bill Hazel, Senator Mark Warner, and the Virginia Center for Health Innovation. We were encouraged to continue to do the work that brought the healthcare community together.

“Health record,” continued on page 3

We want you to take it home and make it your own:
The age of the electronic health record

BY ISAAC L. WORNOM III, MD FACS

When my son Chris was a rising junior at Douglas Freeman High School, we went together to an assembly to get the new laptop that Henrico schools gave to every rising high school student.

Dr. Pruden, the excellent principal of Freeman at the time, stood in front of us and told the students that he wanted them to take those computers home and in the two weeks before school started, “make them their own.”

Well that is just what Chris and his computer-savvy friends did. By the time school started, those little laptops had 10 times as much RAM and more new programs on them than you could shake a stick at. That did not last. The county figured out what had happened and collected the laptops and returned them to their original configuration and made lots of rules to keep it from happening again. The students who made the changes became the go-to people for computer problems at the school.

“Health record,” continued on page 3

Some potential problem areas:

- Disabled clinical decision support alerts that, if used, could have caught a problem.
- Auto complete functions that fill in incorrectly entered data.
- Extra details in the electronic record.
- New programs on the laptop that Henrico schools gave to every rising high school student.
- Disabled clinical decision support alerts that, if used, could have caught a problem.
- Auto complete functions that fill in data incorrectly.
- Sharing of passwords, so that the physicians look like they’re viewing the chart when they actually are not doing so.
- Sloppy documentation, such as incorrectly entered data.

EHRs also create audit trails, according to the report. And guess who likes audit trails? Not just the IRS!

Chip Jones is RAM’s communications and marketing director.

EHRS and malpractice

BY CHIP JONES

As a physician, any discussion of electronic records should start with two words: “audit trail.” Here’s why:

According to the July 2013 issue of the Virginia Medical Law Report, lawyers across the commonwealth are busily adapting to the brave new digital world of patient information. It begins with language itself, one Norfolk lawyer told the publication. “There’s a whole new lexicon, a new language we have to speak.”

“There’s a whole new lexicon, a new language we have to speak.”

Now lawyers also are learning to dig things up in new ways as they perform discovery in malpractice cases, giving up the “stray facts and telling details” they used to find in various folders and log books in hospitals and doctors’ offices.

Before school started, “make them their own.”

There was unanimous support among the participants that the Richmond Academy of Medicine assume a leadership role as catalyst, convener and organizer of a community-wide effort on advance care planning. Everyone agrees that advance care planning is a lifelong process, best begun before a crisis develops.

We shared the outcomes of the conference with health systems, Secretary of Health and Human Resources Bill Hazel, Senator Mark Warner, and the Virginia Center for Health Innovation. We were encouraged to continue to do the work that brought the healthcare community together.

“Health record,” continued on page 3

We want you to take it home and make it your own:
The age of the electronic health record

BY ISAAC L. WORNOM III, MD FACS

When my son Chris was a rising junior at Douglas Freeman High School, we went together to an assembly to get the new laptop that Henrico schools gave to every rising high school student.

Dr. Pruden, the excellent principal of Freeman at the time, stood in front of us and told the students that he wanted them to take those computers home and in the two weeks before school started, “make them their own.”

Well that is just what Chris and his computer-savvy friends did. By the time school started, those little laptops had 10 times as much RAM and more new programs on them than you could shake a stick at. That did not last. The county figured out what had happened and collected the laptops and returned them to their original configuration and made lots of rules to keep it from happening again. The students who made the changes became the go-to people for computer problems at the school.

“Health record,” continued on page 3

Some potential problem areas:

- Disabled clinical decision support alerts that, if used, could have caught a problem.
- Auto complete functions that fill in data incorrectly.
- Sharing of passwords, so that the physicians look like they’re viewing the chart when they actually are not doing so.
- Sloppy documentation, such as incorrectly entered data.

EHRs also create audit trails, according to the report. And guess who likes audit trails? Not just the IRS!

Chip Jones is RAM’s communications and marketing director.
“Vision,” continued from page 1

Together, speaking in one voice, in support of honoring a patient’s choice.

Now we are ready to take the next logical step to support system change—advocacy and education around advance care planning throughout Central Virginia. The Academy desires, as convener and coordinator, to launch an Advance Care Initiative built upon the proven concepts of Respecting Choices®. Respecting Choices is a program started more than 20 years ago in LaCrosse, Wisconsin, to help patients articulate their choices about end-of-life care and put in place systems to ensure that patients’ choices are known and respected. Their experience has shown that this results in improved quality of life and improved patient and family satisfaction with end-of-life care. Their methods have been widely recognized and replicated at many other sites regionally, nationally, and internationally. Respecting Choices is also the platform behind Virginia’s POST pilot projects.

Recently, we invited Central Virginia health systems to join us. We cannot do this work alone, but with their support and guidance we can be a collaborative partner for a community-wide initiative. Health systems joining us would agree to a common emphasis on improving the conversation between patient and provider, not only in word but also in action. Such a commitment requires a collaborative partner to invest in technology that adequately stores and retrieves advance care planning documents; to invest in the training of professionals and laypersons; and to devote the organizational resources needed to implement new programs and services.

To guide the work of this initiative, collaborative partners will appoint two or more professionals to a community steering committee that will oversee the project. The steering committee will articulate the goals and objectives, select pilot sites, and define achievable and measurable markers for success of this work.

Once clinical implementation is underway, we will launch a major grassroots effort to reach citizens through a marketing campaign. Community stakeholders, including religious, civic, legal, and business organizations, will be invited to join in our efforts.

No doubt, all of this requires significant resources. In the spirit of cooperation and leadership, the Academy has committed $100,000 in startup funds provided all health systems join. Health systems were asked to contribute $40,000 a year for two years. We will keep you informed of our conversations and efforts.

It has been an honor to serve as your President for the past two years. I believe that this initiative is the most important thing I have had the privilege to lead. I believe it will result in a significant improvement in the quality of end-of-life care in our community. Because I believe this so strongly, I intend to remain involved with the project. I invite you to join us as we move forward.

United2Heal: Your supplies can help!

BY ALBARA ELSHAER

T

here once was a story from CNN Health about a hospital director in Africa who told of a patient dying of malaria in a room with hundreds of bottles of medicine that could save the man’s life, but no intravenous lines with which to administer it.

A simple item, such as an intravenous line, could mean life or death for an individual in the developing world. Unfortunately, this is all too often what happens around the world. But it doesn’t have to happen that way. So what can be done?

A small group of students in Richmond is working to make a big difference. Thousands of boxes of medical supplies—items such as sterile surgical kits, respirator masks, gloves, syringes, crutches, exam tables, and gauze bandages—are hand-packed on a weekly basis by dedicated members of United2Heal, a humanitarian aid organization at Virginia Commonwealth University.

We, as students, do everything we can to ensure that these supplies are useful, well within the expiration date, and appropriate to ship overseas. After we collect and organize our donated medical supplies, we then determine the logistics of shipping these supplies.

With the help of VCU physicians and faculty, and advisors at the Richmond-based World Pediatric Project, over the past two semesters we have been able to ship approximately 1.5 million worth of medical supplies to Syria and Egypt.

What difference are we making? Our most recent shipment to the Children’s Cancer Hospital in Egypt made it possible to extend the hospital’s operations by providing 500 new beds. Fellow VCU sophomore Karima Abutaleb and I have had the opportunity to visit the hospital in Egypt to evaluate the shipment’s impact and receive feedback on how to improve future shipments.

If we can do all this with the help of key partners in the U.S., imagine how many more people we could serve if others got involved? Help us help others by donating excess medical supplies, surgical kits and even simple items such as examination gloves. We also could use more volunteers to help sort the supplies. Please visit our website, www.united2heal.org, to see our past events, to contact us, or to make a donation.

Since 2010, the number of U.S. hospitals having a basic electronic health record (EHR) has tripled.

Children’s Cancer Hospital in Egypt
This story demonstrates both the generational difference in how technology is viewed and how technology has changed education forever.

Medical has not been immune to these technological changes but was slower to embrace them.

Five years ago when the economy tanked, the Obama administration and Congress passed a stimulus package to help the U.S. economy recover. In that package was money to encourage the wide adoption of electronic health records (EHR) by American medicine. There was also a financial penalty for those who refused to make this change.

Medicine has responded as our government hoped we would and EHRs are now everywhere. They are in the hospitals in which we practice and most of us now use them in our offices every day.

This issue of Ramifications addresses the impact of these new record-keeping methods on the practice of medicine. How they are impacting what we do to care for patients is ongoing and evolving and will continue to do so into the foreseeable future.

The process of creating an electronic health record is very different from the process of hand-writing a note or dictating one. As you click through lists of symptoms in a history and findings on a physical exam, and import lab and X-ray results, the note is created. At the end, though, what is often missing is the thought process of the doctor as he or she comes to a diagnosis and treatment plan.

The notes often appear cookie-cutter and filled with data which are sometimes repeated over and over again in the computer chart. The note that is created is legible and easy to read, and filled with lots of data and information. This can allow a greater level of billing, but it can make it harder for other caregivers to see the thought process of the clinician who cared for the patient.

Who would have known how important that typing class I took in 10th grade would be in 21st century medicine? I find myself free texting and phone conversations, and these records appear as piles of paper on our office fax machine. Our office staff then brings them to our attention so we can do what needs to be done to care for our patients. The end result is more paper, not less.

Making the different systems talk to each other seamlessly can be done but it is expensive. I think this will happen as we move forward and, hopefully, we will all have less paper to deal with in the future. I know we are not there yet. It has always seemed to me that if our government was going to essentially drive us all to use EHRs, it would have chosen one system for the entire country, sort of like the one radar system we have for air traffic controllers. I think the political issues to make this happen were insurmountable.

One of the great hopes is to use data mined from EHRs to improve our health. Some of those same computer-savy high school students who altered the first laptops given out by Henrico County now have computer engineering degrees from prestigious schools and are working for consulting firms inside the Belows trying to figure out how to do that. The paranoid among us think the government will use this information to control us. There is a big difference between health records and email and phone conversations, and these conspiracy theorists may be right.

It is interesting how many fine Richmond physicians have chosen 2013 as the year to retire. There are many reasons we hang up our white coats and put away our stethoscopes and scalpels, but I have heard it said in the lunchroom by some of these retiring docs that the EHR is one of the things that is making them pull the trigger and stop practicing medicine. Some of these physicians never learned to type and I can’t imagine working in this new world without that skill. Others really did not like the changes and are choosing to move on. Going forward, the challenge for all of us is to do what my son and his friends did when they got their first laptops. We have to make it [the EHR] our own. I suspect it will be the generation being trained now that will do that. EHRs will be all they know. Hopefully, the human touch will remain in medicine as this change moves forward. The machines cannot be allowed to win.

Dr. Wornom practices at Richmond Plastic Surgeons and is a past president of RAM. He can be reached at wornom@richmondplasticsurgeons.com.
In 2004, President George W. Bush issued a bold proclamation that most Americans should have electronic health records by 2014. It was recognized at the time that information technology adoption in health care lagged far behind that of other industries, most notably that of banking. Despite the lack of adoption, however, health IT was viewed as necessary—if not sufficient—to drive transformation toward improved quality, safety, efficiency and effectiveness. With just a couple of months left before we reach 2014, it’s an appropriate time to review where we’ve been; where we are; and speculate on where we’re going.

**Where we’ve been**

While good data on EHR adoption in 2004 is scarce, it is generally believed to have been less than 25 percent, with some estimates as low as 5 percent. Locally, practices with EHRs were the exception rather than the rule. Virginia Urology was one of the early adopters, building its own EHR platform in 1992 that even included the ability to import clinical results. Many looked to this practice for experience and inspiration for the work that lay ahead in EHR adoption. At the time, most practices had electronic billing and practice management systems, albeit with varying levels of capability and satisfaction. Hospitals were usually an amalgamation of patient accounting systems and “unintegrated” lab, pharmacy, OR, and radiology systems. The concepts of “health information exchange” and “personal health records” were new and not widely accepted. While e-prescribing was being pursued by a few pioneers, the Surescripts pharmacy gateway was years away from becoming a definitive platform for eRX transactions. Physicians sometimes ask why the U.S. didn’t move to a single solution EHR, thereby improving compatibility between doctors’ offices. Given the lack of EHR adoption and use in 2004, that proposition could have been considered. In fact, the closest we came to such a scenario was when Medicare offered free access to VistA, the EHR utilized by the Department of Veterans Affairs. It was then that I first heard the phrase “free is not cheap enough.” While the VistA software was open-source (and thereby, free), implementation costs and customization ran well over $10,000.

Physicians began taking a serious look at how an EHR would work best in their practice and most concluded that “one size does not fit all.” So it was that the possibility of a single EHR faded as fast as the prospects of a single payer system. All was not lost on the compatibility front, though, as the focus shifted from a single EHR system to adoption of industry-accepted interoperability standards. While still a work-in-progress, these standards became an increasingly important aspect of health IT over the past 10 years.

**Where we are**

So much has changed in the healthcare world in the past 10 years, driven in part by significant incentives provided by CMS for “meaningful use.” By 2011, 54 percent of physicians had adopted an EHR. Almost three-fourths of physicians who have adopted an EHR system report that their system meets “meaningful use” criteria. Eighty-five percent of physicians report being somewhat (47 percent) or very (38 percent) satisfied with their system. Three-fourths of physicians report that their EHR system has resulted in enhanced patient care. And nearly one-half of physicians currently without an EHR plan to have one in place within the next year. (Statistics from NCHS Data Brief No. 98, July 2012)

The increase in EHR adoption is impressive and should be considered an overwhelming success. Perhaps the lofty goal of universal adoption of EHRs by 2014 was ambitious to the point of being unrealistic. I recall a conversation I had with the national coordinator for health information technology shortly after the passage of HITECH when I observed, “It has taken 30 years to get to 30 percent adoption…we can’t possibly get another 70 percent in three years!” He seemed surprised and dismayed by my comment. Being a “glass half full” kind of guy, I still think what has occurred in health IT has been extraordinary, and a deep and broad foundation has been laid for the future.

**Where we’re going**

I tip my hat to all of you who have suffered through the blood, sweat and tears (and costs!) of EHR implementation over the past few years. There’s more to be done, though, and I offer a
few areas to keep in mind as we look to the future:

- Interoperability: Let’s make sure we haven’t unintentionally created even more isolated data silos through EHR deployment.
- Patient engagement: Patients are increasingly demanding not only access to their clinical information, but also the ability to conduct business online (schedule appointments, etc.).
- Mobile devices: Home-based monitoring is ready to explode, but are you ready, willing and able to integrate information from these devices into your EHR?
- Registries and analytics: Most use of EHR systems has been focused on care for individual patients, but increasingly will be leveraged for population health.
- Value-based purchasing and clinical outcomes: Value-based purchasing and clinical outcomes will be commended for the changes you've undertaken in an industry that doesn’t change easily. It’s been a privilege to work alongside you.
- Interoperability: I also can’t remember a time of such change, turbulence and uncertainty. I also can’t remember a time of such promise…promise that will in part be realized through health information technology. I strongly believe EHRs and health information exchange will be accepted as a standard-of-care, and not as optional or discretionary. We have much more work to do to ensure that health IT is as efficient for the physician as it is effective.
- Mobile devices: Having a “day job” of working on health IT and population health is a luxury most of you don’t have…you have to accomplish all this while actually caring for patients! You’re to be commended for the changes you’ve undertaken in an industry that doesn’t change easily. It’s been a privilege to work alongside you.
- Value-based purchasing and clinical outcomes: And if this is all just too stressful to embrace, perhaps we should simply follow the wisdom of Albert Einstein: “I never think about the future—it comes soon enough.”

Michael Matthews is CEO of MedVirginia, He can be reached at mmatthews@medvirginia.net or (804) 359-4500, ext. 4225.

I’ve been in the business for 35 years, and I can’t remember a time of such change, turbulence and uncertainty. I also can’t remember a time of such promise…promise that will in part be realized through health information technology. I strongly believe EHRs and health information exchange will be accepted as a standard-of-care, and not as optional or discretionary. We have much more work to do to ensure that health IT is as efficient for the physician as it is effective.

Having a “day job” of working on health IT and population health is a luxury most of you don’t have...you have to accomplish all this while actually caring for patients! You’re to be commended for the changes you’ve undertaken in an industry that doesn’t change easily. It’s been a privilege to work alongside you.

And if this is all just too stressful to embrace, perhaps we should simply follow the wisdom of Albert Einstein: “I never think about the future—it comes soon enough.”

Michael Matthews is CEO of MedVirginia, He can be reached at mmatthews@medvirginia.net or (804) 359-4500, ext. 4225.
Technology and social distancing— the EMR

BY RICHARD P. WENZEL, MD, MSc.

The sea change in recording the history and physical examination as a result of the electronic medical record (EMR) is remarkable. Those of us witnesses to the before and after eras recall the desperate search for the bundled-up old records, the time-consuming and frustrating attempts to decipher the unique handwriting of prior clinicians, the long queues in front of the radiology film room seeking to review earlier images. Technology has solved key problems for patient care.

But something has been lost with the useful technology. In the pre-EMR era, the team room was a lively place, the buzz of verbal exchanges, as senior clinicians traded ideas with the house staff, reviewed the assessments and plans, engaged the students, and together rounded at the bedside—spending time to illustrate important physical findings.

In contrast, the team room today is relatively quiet, each member now facing a computer screen along the wall as a lonely typist. All eyes gaze at the periphery of the room, none at the center, none at each other, observing the unspoken expressions of the others. As a result we don’t know each other personally as well as we used to—the aspirations, worries, insecurities or confidence levels of students and house staff.

To be fair, the interpersonal distancing created by the new technology has conspired with the residents’ 80-hour workweek and the business focus on patient throughput. Together these forces have transformed the team rooms’ banter to hundreds of syncopated sounds of keyboard strikes. There is a sense of urgency felt but not stated—the need to record so much into the chart as quickly as possible—for the clock is ticking.

In a thoughtful essay published in the Annals of Internal Medicine in 2010, Mike Edmond noted that attending on the wards is “much less fun and exhausting, with limited time for levity, banter and humor. I feel guilty if I ask the residents questions about themselves or what they did over the weekend as they type (and they are always typing), because I’m distracting them and using precious time.”

Physician and author Abraham Verghese wrote about the issue in “Culture Shock—patient as icon, icon as patient,” a 2008 article in The New England Journal of Medicine. Concerned that the time of engagement of house staff and patient is shrinking, he noted, “Patients are handily discussed in the [call room] bunker while the real patients keep the beds warm and ensure that the folders bearing their names stay alive on the computer.” Like Edmond, Verghese is alarmed by the erosion of bedside skills of the modern house staff. “...the bedside is hallowed...
ground, the place where fellow human beings allow us the privilege of looking at, touching, and listening to their bodies. Our skills and discernment must be worthy of such trust.”

What’s amazing in comparing the old and new eras is the stunning increase in length of the daily notes. Some recorders copy and paste the latest laboratory data, radiology findings, special test results such as a cardiac echo; they often paste the notes verbatim from the consultants. Lastly, they list the examination they did and all pending tests. Up to this point, the new report is heavy with data but light on real information—what are now brief are the Assessment and Plan sections.

I cannot help but notice how little I learn about the thinking of today’s clinician, what she really concludes are the key issues, and the summary evidence to support those; the steps to clarify the lingering questions remain unclear. To be sure, the pre-EMR days had considerably less information that is crowding the chart and shortening the follow-up recordings to essential bedside and laboratory findings, and focusing on the critical thinking. Right now the loss of this reflection—the active engagement of expertise, experience and thoughtful pursuit of truth—is an unfortunate adverse effect of technology.

When I was in graduate school for my MSc degree from the London School of Hygiene and Tropical Medicine, I was introduced to the English ritual of teatime—30 minutes in the morning and 30 minutes in the afternoon. Initially I had the misguided thought that this is incredibly wasteful, a loss of productivity time, and one leading to inefficiency. What I learned quickly was that more than 80 percent of the faculty and all of us students showed up in one room for every teatime; and the vast exchange of information, mentoring, sharing of scientific and clinical ideas that occurred in those 30-minute periods was something never seen in the U.S.

Of course the U.S. culture is different; we don’t get RVUs or reimbursement for that time; we feel tremendous pressure to keep going (typing). Yet more direct face-to-face talking with other clinicians, house staff and students would likely be more efficient. Importantly, it would add quality to our lives, quality lost with the advent of technology.

I am reminded of the words of author and philosopher Robert Pirsig from his iconic book “Zen and the Art of Motorcycle Maintenance”: “We’re in such a hurry most of the time we never get much chance to talk. The result is a kind of endless day-to-day shallowness, a monotonous that leaves a person wondering years later where all the time went.”

With every distancing technology, including the EMR, we lose some part of our humanity—the connection between patient and physician, teacher and student, physician and colleague. We are marginalizing bedside teaching on the wards and the true exchange of information. With all the useful advance of technology we risk the loss of our key values. The challenge now is not to be a victim of technology but to seek ways to remold it to enhance the quality of life.

Dr. Wenzel is Professor and Former Chair of the VCU Department of Internal Medicine. He is the author of a medical thriller, “Labyrinth of Terror.”
At first glance, storing patient data in “the cloud” sounded intriguing to the IT experts at Virginia Eye Institute. Maybe it would help save money to back up their new electronic medical records system. It makes sense to look for savings, given that the costs for EHRs can be considerable—estimates range from $5,000 to more than $50,000 per provider. And that doesn’t include hiring consultants to work through the many details of customizing, installing, and ensuring quality controls. Ka-ching! Throw in hardware upgrades, lost productivity and the total price tag can easily top $1 million.

“So I can see why smaller practices go with the cloud,” said Eric Hays, vice president of operations at VEI. “But at VEI—a practice with 38 providers who need customized records-keeping at 11 locations—Hays spotted a big problem with any business plan that would put his patients’ medical records in the hands of third-party servers.

“Then your [electronic medical records] supplier is keeping your data, and if they were to go under, you’d have to make sure the contract has language that you’d get ownership of the data,” Hays said. “That’s why we like to have it internalized,” by using an offsite data center—Peak 10—which offers special security measures (such as fingerprint access), electrical backups, and other data recovery components.

“I know the model is moving to the cloud, but in terms of a security issue, it’s nice to have control,” Hays said. Yet another practice administrator, Kit Young at Richmond Plastic Surgeons, takes a slightly sunnier view. “Two years ago I may not have considered the cloud, but in today’s market, there are many good options worth considering during the evaluation process.”

Decisions, decisions…. Interviews with practice managers and doctors show how wide open—and sometimes confusing—this new technology terrain can be. They shared different approaches to how they customize records for physicians and nurses, working in billing and communications features along the way. And, depending on their Medicare and Medicaid populations, they expressed varying degrees of interest in meeting the federal government’s Meaningful Use standards.

But while their needs and approaches differed, from pediatricians to plastic surgeons to OB/GYN offices, there was agreement to never forget the old adage, caveat emptor, or “let the buyer beware.”

“When we first got quotes for IT, they were based on the minimum standards from the vendor,” recalled Leslie Bachmann, practice manager at the Skin Surgery Center of Virginia. She soon discovered those “standards” were “the minimum to run their software and nothing else.” It will cost more once “you calculate all of your needs.”

These practice managers, and one physician interviewed, said it’s important to determine all of the features needed and then have the software vendor provide solid price quotes. “Practices have other programs, outside of their patient medical records, that are required to
run their day-to-day operations.” Her advice: “Work with your IT vendor to evaluate the cost of running all programs” if you want a true cost of upgrading your office.

Understand what you need the system to do and what data you need to collect. Are you going to participate in Meaningful Use, the Patient-Centered Medical Home, an Accountable Care Organization (ACO), and the Physician Quality Reporting System (PQRS)? If so, what PQRS measures would you like to collect data on? Not all vendors have this built in.

How hard is it to retrieve data—and can you report out of the system, or do you need additional features (at a cost) to do so?

Bottom line, said Young: “Make sure you have all you want listed in the final agreement before signing.”

In the case of the Skin Surgery Center, which specializes in Mohs surgery, Bachmann and practice founder Dr. Christine Rausch wanted to make sure they purchased a system that guaranteed the best experience for patients and practitioners.

They spent hours researching, meeting with vendors, talking with other physicians and other practice managers, and paying visits to medical practices to see their systems. They also exercised self-discipline not to be driven by the government’s deadlines for Meaningful Use. But because they have a number of Medicare patients and a deadline approaching, Dr. Rausch said in late summer, “We finally decided we had to get it done.”

While Rausch’s practice is smaller than VEI, she tackled many of the same data storage and transmission issues. They also opted for an in-house data storage system, Rausch said, “because then if you change EMRs you don’t have to worry about [access] to your own data. The downside is there’s more maintenance and cost, and it’s not as accessible when you’re out of the office.”

After they finally settled on a customized system for dermatologists, they faced the next big decision point: How to get it up and running?

Super users

Young, administrator and director of information technology at Richmond Plastic Surgeons, gave this advice for preparing for the “go live” date for practices still transitioning to EMRs: “You can begin by having your patient forms ask the same questions in the same format that you’ll be asking in the electronic record.”

With the Meaningful Use requirements—such as obtaining patients’ ethnicities—getting everyone on the same page as early as possible is even more essential, said Young, who has supervised the installation of records systems at several practices. “That’s something I’ll do two to three months out while working to build the system” to ensure the staff and practitioners “become accustomed to asking the question in the form that’s being asked” in the electronic record.

Three months ahead of the “go live” date at Pediatric Associates of Richmond, “We pre-scanned a lot of charts,” said office manager Jo DiPerna. This helped speed up the adoption of the electronic records, and for legal reasons, it’s crucial to keep consistent records on paper and in digital charts.

Once this paper-to-digital work is done, it’s time to do something no EMR vendor can do for you: organize staff training and implementation.

“Think about the work flow of your office, and how it ties in,” said Nicole Midulla, front desk supervisor at Pediatric Associates. So, for

“Electronic road,” continued on page 10
example, when nurses and other office staff needed training in how to enter procedure codes, Midulla took screen shots of each new code in order to show everyone how it would look in the new system.

Before going “live,” Midulla asked her staff to come in over the weekend for a dry run, with each person entering 25 appointments into the EMR system. “It gave them time to ask questions without tying up the phone lines,” DiPerna said.

At Virginia Ear, Nose and Throat, CEO Susan Shackelford said, “From my perspective, the best thing you can do is spend however much time it takes you to do the customization up front” for your system. And no matter how much you prepare to launch it, “When you go live, you must have ‘super users’ there because you can not think of all the things that are going to happen in real life.”

Doctors also need time for training and hand-holding before the systems are active. A doughnut or two also doesn’t hurt. “Physicians in medical school and in residencies are taught what their styles or routine is in an exam,” said Young, “and an electronic health record really changes the dynamic.”

Electronic records should be configured to meet the treatment styles of physicians, who probably will show varying degrees of comfort at first. This isn’t simply a generational issue, Young observed. “I’ve had young physicians who are just as frustrated” by digitization as older ones.

At VEI, Hays said, “90 percent of our doctors’ questions are about the speed of the system.” Using large screen desktop computers—mandatory in the visually-driven world of eye care—it was important to invest in making sure the software runs as quickly as possible. Even then, he said, “We still had issues.”

In this age of digital doctoring, new problems are bound to arise when electronic records become as much of a staple of practice as a stethoscope. Which is why, said Hays, “We hired a corporate trainer. Because eventually the support we were expecting from the vendor goes away.”

VEI’s trainer runs on regular “lunch and learn” sessions, and the practice also started a help desk to answer questions about everyday glitches (printers that don’t work, glitches in data fields, and so on).

According to Young, many software systems have testing at the end of training modules. “Sometimes software is a version or two ahead of the training,” she said. “I found this was true with a few different office-based systems, so I would develop my own how-to cheat sheets.”

Over time, Young said, “I have often found that many clinicians learn by doing: see one, teach one, do one.” During training, she creates a “test patient” and works with the physician to enter information on the sample patient to practice “moving through the system.”

She cautioned, “Just make sure you are able to designate in the system that this is a test patient, and the data does not result in final quality or meaningful use reports.”

EMRs and patient safety

Like any major shift in workplace flow and medical practice, the plusses and minuses seem to balance out. But when it comes to improving patient safety, the switch to electronic health records is a definite plus.

“We’ve been able to mine our data and that extra information actually improves our patient safety,” said Brenda Burgess, practice manager of Virginia Women’s Center. Her practice “mines” the data weekly, “so if there’s something missing in a record, we identify it in real time, and address it.”

This data-mining capacity didn’t come with the practice’s original EMR software. “We had to take the technology to the next level,” she said. And given the improved safety features they’ve built-in, Burgess said the effort—and the cost—was worth it.

Chip Jones is RAM’s communications and marketing director.
Please join us in welcoming Francie James, MD and Meghana Gowda, MD to Virginia Urology and to the medical community of central Virginia.

Dr. James obtained her medical degree from the Medical University of South Carolina in 2007. She completed her general surgery internship and urologic residency at Eastern Virginia Medical School.

Following residency Dr. James completed a one year fellowship in genitourinary reconstructive surgery at Eastern Virginia Medical School. Her clinical interests include general urology, reconstructive surgery, male and female urinary incontinence, and urethral stricture disease.

Dr. James grew up in South Carolina and attended Tulane University in New Orleans for her undergraduate studies. She and her husband Ennis now reside in Richmond with their young daughter.

She will be seeing patients in our Stony Point and Reynolds Crossing locations.

Dr. Gowda joins Virginia Urology as our first urogynecologist and one of the few in the region to have completed an accredited, 3-year combined fellowship program in Female Pelvic Medicine & Reconstructive Surgery. Dr. Gowda has been trained in clinical & surgical options for women with pelvic floor disorders and brings this expertise to the Urogynecology practice of Virginia Urology.

Dr. Gowda was awarded her undergraduate and medical degrees from Virginia Commonwealth University. Following her time in Richmond, she completed her residency training in Obstetrics and Gynecology at New York University and Bellevue Hospital. Dr. Gowda then completed her fellowship in Female Pelvic Medicine & Reconstructive Surgery at Vanderbilt University in Nashville, Tennessee. Her clinical interests include female incontinence, pelvic organ prolapse, minimally invasive techniques, and complicated childbirth injuries.

She will be seeing patients in our St. Francis, Stony Point and Reynolds Crossing locations.

Virginia Urology Women’s Health is a division of Virginia Urology. Appointments can be made by calling 804-288-0339.
E-mailing and texting are efficient, convenient, and direct methods to communicate in the dental and health care world, but they can be fraught with inadvertent security breaches. When e-mailing or texting replaces direct consultations and communication with dental colleagues, the dental provider must take steps to ensure the e-mails and texts are secure. Without appropriate safeguards, e-mailing and texting can lead to violations of the Health Insurance Portability and Accountability Act (HIPAA). Health care providers are smartphone “super-users.” According to Manhattan Research, over 81 percent of health care providers use a smartphone to communicate and access health information. The attractions are obvious: Texting and e-mailing reduce time waiting for colleagues to call back and may expedite health care by allowing necessary patient data to be sent and received quickly. However, according to a member survey conducted by the College of Healthcare Information Management Executives, 57.6 percent of those surveyed did not use encryption software. The underlying reasons for poor compliance with encryption could be due to lack of technical knowledge or to avoid the inconvenience of sending a message to someone who may not be able to unencrypt it. With penalties starting at $50,000 per HIPAA violation, safeguarding electronic messages should be of utmost priority. In addition to encrypting the messages, consider installing autolock and remote wiping programs on smartphones and computers. Autolock will lock the device when it is not in use, and requires a password to unlock it. This feature needs to be activated in the settings of the smartphone by activat-
ing the “screen lock” feature so that the phone will automatically lock after the phone has been inactive for a designated period of time. Remote wiping programs can erase data, texts, and e-mail remotely should the phone be compromised. Depending on the type of smartphone, there are different remote wiping applications that either come with the phone or can be downloaded. Both types of safeguards provide additional protection if a device is lost or stolen.

Ensure accuracy to avoid liability concerns
A cavalier attitude when composing an electronic message can pose a legal risk. The informal nature of some messages may at times lead to using shorthand, which can increase miscommunication. Additionally, deleted messages are never fully deleted, as metadata (the “data behind the data”) is also producible in a lawsuit. It’s important to ensure accuracy—particularly with consultations, personal health information, or any other important text communication.

Finally, electronic messages cannot substitute for a dialogue with a colleague concerning a patient. If there is a critical matter or any doubt about the communication, pick up the phone.

Use available safeguards
In some cases, an electronic record vendor may offer a secure e-mail network option to clients. If this is the case, be certain that the e-mail recipient is also utilizing encryption in response to your messages. Be aware that some vendor contracts attempt to shift liability risks resulting from faulty software design or decision support data onto the provider. The contract may also give rights to the vendor to utilize patient or provider data.

Take Steps to Protect Your Practice
Consider the following steps to safeguard your practice:
• Enable encryption on your electronic devices.
• Have a texting policy that outlines the acceptable types of text communication and situations when a phone call is warranted.
• Report to the practice’s privacy officer any incidents of lost devices or data breaches.
• Install autolock and remote wiping programs to prevent lost devices from becoming data breaches.
• Know your recipient, and double-check the “send” field to prevent sending confidential information to the wrong person.
• Ensure the metadata retention policy of the device is consistent with the record retention policy, and/or in accordance with a legal preservation order.

The guidelines suggested here are not rules, do not constitute legal advice, and do not ensure a successful outcome. The ultimate decision regarding the appropriateness of any treatment must be made by each health care provider in light of all circumstances prevailing in the individual situation and in accordance with the laws of the jurisdiction in which the care is rendered.

©2013 The Doctors Company (www.thedoctors.com).

As the nation’s largest physician-owned medical malpractice insurer, our insights into the practice of internal medicine have helped earn us the exclusive endorsement of the Richmond Academy of Medicine and have made us the first choice for RAM members. When your reputation and livelihood are on the line, only one carrier can give you the assurance that today’s challenging practice environment demands—The Doctors Company. To learn more, call 866.990.3001 or visit www.thedoctors.com.

That’s the percent of 114 countries around the world reporting most patient data is still collected on paper. Only 45 percent of high income countries reported some level of adoption of electronic records.

Source: World Health Organization, 2009 survey

That's the percent of 114 countries around the world reporting most patient data is still collected on paper.
VCS: Taking care of Virginia’s hearts since 1977

BY LISA CRUTCHFIELD

As Virginia Cardiovascular Specialists was beginning to make its mark in Richmond in the late 1970s, its co-founder traveled to Europe to study with the renowned physician Andreas Gruentzig, a pioneer of balloon angioplasty techniques. “Bill [Dr. William Holland] stayed with him for several weeks and learned how to do it,” recalled Dr. Gan Dunnington, a cardiologist who’s been with the practice for decades.

Holland brought the skills back to Richmond, trained his colleagues and over the years improved care and treatment for countless patients. That spirit of cooperation continues today. A commitment to learning the latest techniques—and sharing that information—remains a cornerstone of VCS. “We’ve shared knowledge and stayed ahead of the curve,” said Dunnington.

As the largest independent cardiology practice in Central Virginia, VCS is committed to being at the forefront of clinical breakthroughs, improving outcomes for patients and saving lives. “We’ve done a lot of firsts in the state,” said Dr. Shelton Thomas, the group’s president. Some of those firsts over VCS’ three decades include:

- Coronary stents
- Coronary vein graph
- Carotid stenting
- CRT device ICD
- Hybrid maze
- First robotic atrial fibrillation ablation
- Stand-alone permanent pacemakers
- CT heart scan and calcium screen/score
- Coronary angioplasty
- Ventricular tachycardia ablation using the Impella left ventricular assist device

“We feed off each other. One guy can take the lead and spread the expertise around the practice,” said Dr. Charles Joyner, who has been with VCS for a decade.

At VCS, 38 cardiologists practice in seven offices and at many area hospitals. All VCS physicians are board-certified, and many also have additional subspecialty training in cardiovascular intervention, carotid stenting, CT angiography, electrophysiology and peripheral vascular disease.

The practice was founded in 1977 by Holland and Dr. Eric Kemp. Dr. John Fitzgerald joined soon after, followed by Dunnington. From there, the group has added many new physicians and absorbed several other practices over the years. Pulmonary medicine went out, vascular came in.

As the practice grew in size and in scope, it also became more sophisticated. “When we started out, Drs. Kemp, Fitzgerald, Holland and I would meet out in the parking lot around 11 o’clock and that was it,” recalled Dunnington.

As VCS has grown, it’s gotten a little more difficult to meet in the parking lot between patients. A highly organized system of governance has replaced those get-togethers, with a pod system and regular physician and shareholder meetings. But VCS enjoys its status as an independent practice and tries to allow its physicians to have a fair amount of independence too, said Thomas.

In all, VCS boasts about 200 employees, making it one of the largest independent cardiology practices in the commonwealth. Its size has allowed VCS to hire well-qualified administration and staff, in addition to its cardiologists.

“We focus on hiring the best staff that will support our physicians and ensure their efficiency. These physicians have been really good about investing in their infrastructure,” said Executive Director Ann Honeycutt, who joined VCS after a career at Bon Secours. “We have the ability to run things well, improve the patient experience, and from a business office standpoint, keep [practice] viable. That’s essential, because, sadly, getting paid for the work doctors do has gotten very complex.”

That attention to detail is something the physicians appreciate, said Joyner. He also appreciates how administrators and practice leaders are proactive in issues that could influence the field of medicine.

“We are able to recognize some of these things that end up affecting all cardiologists,” he said.

By staying in tune with local and national politics and the American College of Cardiology, VCS can flag issues that it feels it should act on. “We’ve got a lot of leverage as a large group to do that,” said Joyner.

Thomas agrees. “Part of our job in this as good practitioners of cardiology is to ensure that we have a voice in some of the legislative venues or organizations that regulate our work.”

Case in point: In the late 1990s, the group was part of a successful lobby to change laws to allow nuclear medicine to be performed in medi-
We’ve seen a decrease in deaths from cardiovascular disease with the advent of improved medicine and stenting, and our ability to intervene in heart attacks within that critical 90-minute window.

“So we’ve decreased mortality. But the problem with that is that increased morbidity is still there. People are living longer with heart disease. We’re seeing more [atrial fibrillation], arrhythmias and more heart failure. I think the true challenge is keeping these people living longer and staying out of the hospital.”

VCS has a wealth of new techniques and tools to improve a patient’s chances of survival and “VCS,” continued on page 16.
VCS, continued from page 15

quality of life, including:
• New vascular technologies to help restore blood flow and avoid amputations
• Transcatheter aortic valve replacement (TAVR)
• Lower levels of radiation exposure in scanners
• New therapies such as hybrid ablation for arrhythmias and atrial fibrillation

VCS is also on the forefront of developing new ideas by participating in research studies. The practice employs two full-time research nurses and is looking to expand its program. There’s also increased interest in remotely monitoring patients to prevent readmissions, either with telemetry or the use of physician extenders. “I feel like we’ve come full circle,” said Coble. “In a sense, we’re making house calls again, using technology.” “It’s very satisfying to fix people,” said Dunnington. “And it’s also very interesting to note that even after 35 years, we haven’t seen everything.”

Lisa Crutchfield is a Richmond-based freelance writer.

Let’s outsmart cancer.

You’ve dedicated your life to the health of your patients. So when cancer comes into the picture, you want to refer them to the best team to help them fight. You’ll find that team at Virginia Cancer Institute. Our group includes four of Richmond Magazine’s five “Top Docs” for Oncology, and every physician here is committed to bringing the world’s latest advancements in cancer treatment to Central Virginia. We’re also focused on helping your patients live as full a life as possible while they’re battling cancer. Because we know that’s what you’d want for them, too.

Call us or visit vacancer.com to learn more about the latest cancer treatments from the independent practitioners at Virginia Cancer Institute.