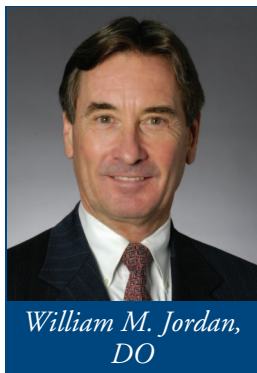


Electronic Health Records: A Community Practitioner's Perspective



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How did you select your electronic health record (EHR) system?

We went live with our first EHR in July 1998, after a few years of searching. The choice back then was fairly easy due to the limited number of medical oncology-specific applications with the attributes that met our goals and that offered the ability to perform in-depth queries. Even with that

in mind, we chose an EHR that was still in the development phase, and we partnered in that process. The EHR that we have now had for 3 years was chosen because of its oncology-specific attributes, the ability to query the data, its performance (speed), and because the company is very sound financially, which gives confidence that ongoing development will occur.

What functional elements do you consider to be important?

A deep understanding of the flow of a multidisciplinary oncology organization must be translated into the attributes of the chosen EHR. Those attributes must support every user, not just the physicians. The elements that are essential for us include the usual general medical information, detailed regimen management, recording of nursing processes and lab values, and all prescribed drugs. The clinical record itself must record the disease and treatment related data in-depth. That includes disease-specific staging, cell type and related markers, response to therapy, and toxicity. Recording the intent of the chosen therapy (curative, palliative, and so on) and the reason a regimen is discontinued or delayed is important as well. Practical work flow attributes are necessary for sound adoption of the EHR by staff. These include remote simultaneous accessibility from multiple work stations and users (including home), the ability to enter scanned documents, automatic printing and faxing, typing or dictating notes, spell check, allergy alerts, laboratory flow sheets, and interfaces with lab and billing software. In addition to medical oncology, our practice has radiation therapy, positron emission tomography, computed tomography, and nuclear imaging, support services, retail pharmacy, and other services. Every discipline and service must have an interface to the EHR or access in a format that works for them. The EHR should be customizable to fit the needs of the practice and flexible so that attributes can be changed or added.

Finally, there are two deal-killer elements that are absolutes. The first is speed. A slow EHR will halt its use in its tracks. It must be fast, fast, fast, and that requires connectivity that's fast—usually a T1 line. The second relates to how the data are input into the system. It must be codified in order for software queries to work. The system must be a primary point-and-click type, whereby it asks the user a question in clinical language that becomes a code in computer language. A manufacturer that praises its system because it's easy to dictate into probably has a system that doesn't provide the ability to extract meaningful reports.

What advice would you give others in terms of implementation issues?

An organization must be committed to the EHR concept; their doctors must express that commitment to all staff members and must have a strong physician leader and "super user" to lead the charge. They must understand the financial, time, and manpower implications. Homework is vital, and visiting experienced practices offers invaluable information that cannot be remotely gleaned otherwise. They need to have a clear vision of the purpose of going electronic and make decisions that support that purpose. They should know the manufacturer's background and understand its commitment to ongoing development. Finally, before implementation, all users should be very well trained and have considerable experience using the system in simulation—do not underestimate a physician's belief that he or she doesn't need training.

Do you have any sense of your return on investment (ROI) yet, and how do you plan on measuring it?

We have found that directly measuring an ROI on an EHR is not really possible, at least for us. However, we do have some surrogates that give us insight into its value. We know that nursing time to record chemotherapy delivery is decreased compared with manually recording it on paper. Our pharmacy uses the system to prepare chemotherapy for the next day at all five of our clinics, resulting in inventory management and clear savings. Our system autofaxes, so when our docs complete their note, it will automatically go to the fax machines of the referring physicians. Our billing staff uses the system daily to confirm diagnoses and procedures, and we record the Demonstration Project and other questionnaires electronically.

Having the ability to automatically file insurance from the point of service and defining the evaluation and management billing code automatically using the Centers for Medicare & Medicaid Services definitions can save time and avoid legal

issues. There are many such work flow–related time and hassle savers in a good EHR. The ability to query the system and to examine variances in treatment choices and outcomes probably provides the best opportunity for a meaningful investment return. It takes time to build the electronic database and perseverance in looking for answers. Every other industry applies this concept, and the complexity of medicine, especially oncology, demands that we do as well.

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Disclaimer: The authors are not recommending any particular type of software service.

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