Electronic Records Are Putting VA in Command

Advanced computer system captures data, serves clinicians, supports quality improvement efforts.

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Over the last decade, health care in the Department of Veterans Affairs has transformed itself from a notorious near-failure to a national model for quality improvement, leaving many asking how they can incorporate those lessons.

The answer may lie in part with the department's electronic health record system. Known as VistA (Veterans Health Information Systems and Technology Architecture), the system recently received the Innovations in American Government Award—a top honor from Harvard University's Kennedy School of Government.

The award was given to seven government programs that each took a unique approach to meeting community needs. All recipients were given a $100,000 grant to share the factors behind their success.

For Dr. Douglas J. Turner, the VA is clearly doing something right when it comes to health information technology (IT). Dr. Turner, who is chief of general surgery for the VA Maryland Health Care System at the Baltimore VA Medical Center and is on the surgery faculty at the University of Maryland, Baltimore, has a foot in both the VA system and the private sector.

At the University of Maryland Medical Center, he works with at least two different computer systems for reporting patient variables, as well as consulting with electronic and paper sources to get information he needs to see patients. In contrast, at the VA, every clinic is connected in the VistA system with a single patient identifier. "Everything is in the computer," he said.

The VA computerized patient record system, which sits atop the VistA platform, includes the physician's notes, lab results, and results of consults and surgical procedures. It also generally includes information from visits made outside the system. A hard copy of the clinical record from an outside visit can be scanned into the VA system and made available within a day.

Quality of care has improved since the implementation of VistA, Dr. Turner said. The system includes a check for drug-drug interactions plus several other alerts that let the physician know what's been going on with the patient since the last visit. "Hands down, I would take the VA computer [system] anywhere," Dr. Turner concluded.

VA officials began building the first generation of the computerized patient record system in the late 1980s out of a need to deal with the increasing number of veterans coming into the system, while resources remained tight, said Linda Fischetti, R.N., acting chief health informatics officer at the Veterans Health Administration's Office of Information. "We had to find ways that we could reduce redundancies and care for more patients."

And the move to an electronic system was driven largely by clinicians who said they needed better tools. "We had clinicians actively saying, 'We need this, we need this, we need this,' " Ms. Fischetti said.

The idea was to create a single system with robust functionality in every health care environment—the inpatient hospital, the outpatient hospital, the long-term care facility, and clinics within the community. The current system is the second generation and VA officials continue to modernize it, Ms. Fischetti said. Today the system allows VA clinicians access to complete historical information on their patients, as well as real-time clinical reminders and real-time decision support.

The No. 1 lesson from the VA experience is that the system must be driven by the needs of the clinician, Ms. Fischetti said. The system also needs to do more than just replace the paper chart. If the health IT product does not add value for physicians, she said, they might not adopt it. But she noted that the VA, as both the payer and provider of health care services, distinguishes itself from most U.S. care providers. "We are definitely different because we have the alignment of the payer and provider within our own enterprise."

Although the VA is a unique system, there are lessons that can be applied in large hospital systems and even in solo physician practices, said Tom Leary, director of federal affairs at the Healthcare Information and Management Systems Society. For example, successful adoption of a health IT system requires buy-in from clinician leadership. Although clinician use of a system can be mandated to some extent in any organization, it does not produce the same results unless physicians and nurses want to use the technology, Mr. Leary said. Success also depends on getting a return on investment—improvement in quality and cost-effectiveness of care—as seen in VistA.

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

Other systems can also learn from the VA's approach to designing the system with the needs of its clinicians in mind, said Dr. Dennis Weaver, acting chief medical officer for the National Alliance for Health Information Technology. "You've got to build it for the clinicians," he said.

But that doesn't mean just automating patient charts, Dr. Weaver said, because recreating paper processes doesn't work. Physicians and administrators who are selecting an electronic health record system need to resist the urge to "pave the cow path." They must let clinicians know up front that the work flow is going to change. ■

POLICY & PRACTICE

Easing Use of Experimental Drugs

The Food and Drug Administration is proposing to widen access to experimental drugs. The agency has been accused by patient advocates and some drug makers of obfuscating the criteria physicians need to seek to prescribe investigational drugs. In 2003, an Arlington, Va.–based advocacy group, the Abigail Alliance, sued the FDA to get unfettered access to unapproved therapies. The plaintiffs were backed by a federal appeals court in May 2006, and a rehearing of the case is expected to begin in March. In the meantime, the FDA's proposed rule, published on Dec. 14, said the agency would make it easier for physicians to access experimental therapies, and for manufacturers to make them available. "FDA hopes this proposal will increase awareness in the health care community of the range of options available for obtaining experimental drugs for seriously ill patients," Dr. Janet Woodcock, FDA deputy commissioner for operations, said in a statement. A separate proposed rule would make it easier for manufacturers to recover costs. In a statement, the Abigail Alliance said the FDA proposals "merely clarify their existing policies."

Stem Cell Support Drops Slightly

Most of the public supports the use of human embryonic stem cells for medical research, but that support may be faltering slightly, according to a new poll from Virginia Commonwealth University, Richmond. The survey, which included 1,000 adults, found that 54% of respondents favored stem cell research in 2006, down from 58% in a similar VCU poll in 2005. The number of respondents who opposed stem cell research climbed from 32% in 2005 to 37% in the recent 2006 survey. However, when asked if they would support the use of embryonic stem cells to find a treatment for themselves or a family member with Parkinson's disease or spinal cord injury, 70% of respondents said yes. Only 21% would not support the use of stem cells in that situation, according to the 2006 poll.

Lax Enforcement of Ad Regulations

FDA issued fewer violation letters regarding direct-to-consumer drug advertising during 2002-2005 than it did in previous years, the Government Accountability Office reported. Further, FDA took longer to send such letters to drug manufacturers, said the watchdog agency, pointing out that the industry spent $4.2 billion in 2005 on DTC advertising. Such advertisements can be positive—by encouraging consumers to talk to physicians—but can also increase spending on the advertised drug and other drugs to treat the same condition, the GAO said in its December report. GAO said that it took 4 months for the agency to draft, review, approve, and issue a letter in 2002-2005, compared with 2 weeks during 1997-2001, and that it issued 8-11 letters a year, compared with 15-25 previously. Although drug companies often complied with orders to cease and desist, sometimes the manufacturers would later put out similar violative materials for the same drugs, the GAO said. The GAO said it had noted in a previous report in 2002 that the FDA's violation letter process was being delayed by internal reviews. That has not improved, according to December's report, which recommended that FDA set criteria for prioritizing advertisements for review, systematically apply the criteria, and track materials reviewed.

NYC Bans Trans Fat

In a move aimed at improving the healthfulness of restaurant food, the New York City Board of Health recently voted to require that all of the city's restaurants remove artificial *trans* fats from foods by July 2008. The mandate gives restaurants until July 1, 2007, to switch to oils, margarines, and shortenings that have less than 0.5 grams of *trans* fat per serving. By July 1, 2008, all other food items sold in restaurants must meet the same mark. New York is the first city to make such a move. The move was praised by the American Diabetes Association: "When you consider that many American adults—and their children—are eating out several times a week, it is even more difficult to avoid *trans* fats and maintain a healthy diet," said Dr. Peter Sheehan, president of the American Diabetes Association's New York City Leadership Council. "For more than 700,000 New York City adults diagnosed with diabetes, the passage of this proposal eliminates a major source of artificial *trans* fats and should serve as a model for other cities to consider." In testimony in 2006 before the New York City Board of Health, the New York State Restaurant Association said that although the measure is well intentioned, it will not achieve the health benefits being sought. The 18-month transition does not give restaurateurs enough time to find healthful alternatives, the group said. Many will end up returning to the use of oils high in saturated fats.

Changes to HSA Rules

Legislation signed into law in December eases the use of health savings accounts. Previously, HSA participants could contribute only the amount they were required to pay out of pocket before their high-deductible health insurance policies kicked in. Under the new law, participants can contribute up to $2,700 for individual accounts and $5,450 for family accounts. The measure also allows employers to contribute more to the HSA accounts of non–highly compensated workers, and allows a one-time, tax-free rollover of individual retirement account funds into an HSA. "These provisions will help many Americans find more affordable and tax-preferred ways to pay for health care costs," said James A. Klein, president of the American Benefits Council, an organization of large employers and health plan administrators.

—From staff reports