

Cost and Practice Size Limit Adoption of EHRs

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LOS ANGELES — Cost is the most frequently cited barrier to adoption of electronic health records, according to two surveys presented in posters at the annual meeting of the Society of General Internal Medicine.

Although electronic health records (EHRs) appear to increase the efficiency and quality of medical care, few published studies have assessed how many ambulatory care practices in the United States currently use EHRs.

Dr. Steven Simon and his team at Harvard Medical School, Boston, conducted a survey of physicians, and Madeline McCarthy from Partners Healthcare System Inc., also in Boston, surveyed practice managers. Both studies were done in Massachusetts in 2005, and both revealed barriers to making a smooth transition from paper-based record systems to EHRs.

Overall, 23% of physicians who responded to the Harvard survey used EHRs in their practices—most of them (58%) for at least the previous 3 years. A larger proportion of multispecialty practices (35%) than primary care practices (25%) were using EHRs.

Larger practices (seven or more physicians) were more likely to adopt EHRs than were solo practices (57% vs. 15%). Hospital-based practices or those with computerized office systems were also more likely to use EHRs.

Barriers to adopting EHRs identified by survey respondents included start-up costs (75%), maintenance costs (72%), loss of productivity while learning (73%), lack of computer skills (57%), skepticism about benefits (54%), and privacy or security concerns (48%). Physicians who listed start-up costs and loss of productivity as reasons not to adopt EHRs were significantly less likely to use EHRs in their practices.

In Ms. McCarthy's study, 29% of practice managers reported using EHRs in their practices: 26% of primary-care-only and 28% of specialty-care-only practices had adopted EHRs, compared with 40% of multispecialty practices.

Practices that had computerized claims and/or billing systems, computerized scheduling systems, or computerized prescribing systems were significantly more likely to have also adopted EHRs than were practices without such systems.

Among practices in which EHRs allowed computerized retrieval of laboratory and radiology results, 88% of practices reported that a majority of their clinicians actively use these features. Also, survey responses showed that in 72% of practices with electronic decision support, the majority of clinicians actively use that feature.

The findings showed that among the practices that do not currently use EHRs, the majority plan to implement them within 3-5 years. Surprisingly, however, 37% of practices did not plan to establish

EHRs in the foreseeable future. Cost was the most frequent (50%) reason given for not implementing EHRs.

Although both surveys were limited in that the study population was from a single state, they did target practices that varied widely in terms of number of physicians, specialties, hospital associations, and urban vs. rural location. ■

UPCOMING MEETINGS

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And Related Disorders

World Transplant Congress

American Academy of Dermatology: Academy 2006

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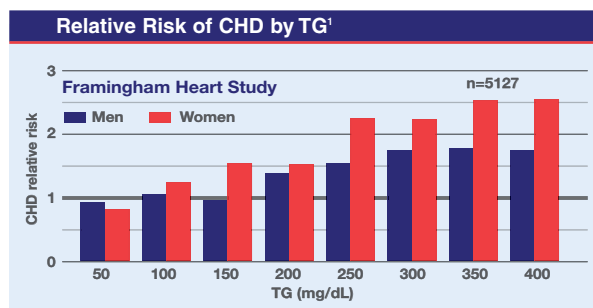


What TG means to a woman's heart

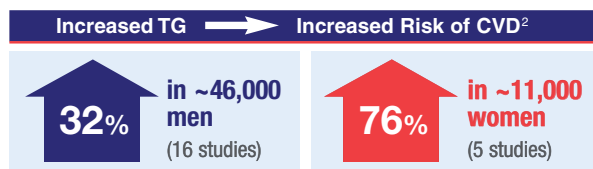


Elevated Triglycerides Make a Difference in Women's Risk of CHD

While great attention and clinical efforts have been directed toward LDL-C-lowering, the Framingham Heart Study 30-year follow-up clearly showed that elevated triglycerides (TG) are also associated with an increased relative risk of coronary heart disease (CHD)—especially in women.¹



In addition, meta-analyses demonstrated that every 1 mmol/L (89 mg/dL) increase in TG increased cardiovascular disease (CVD) risk by²:



CHD is the #1 Killer of Women

The effect of elevated TG in women is important to keep in mind in view of the fact that CHD is the single leading cause of death among American women, claiming nearly 500,000 lives each year.³ Menopausal women are particularly at risk, with CHD rates 2 to 3 times those of women the same age who are premenopausal.³

CHD Risks With Diabetes or Metabolic Syndrome* in Women: Role of TG and HDL-C

Of the estimated 16 million Americans with diabetes, more than half are women.⁴ In women, diabetes is a powerful risk factor for CHD, increasing CHD risk 3-fold to 7-fold compared to a 2-fold to 3-fold increase in men.⁵ It has also been shown that metabolic syndrome is associated with a 2-fold risk of CHD mortality in women.⁶ **It is important to note that the most common pattern of dyslipidemia in patients with type 2 diabetes is elevated TG levels and decreased HDL-C levels.⁷**

*At least 3 of the 5 criteria: abdominal obesity with waist circumference >102 cm in men and >88 cm in women; triglycerides ≥150 mg/dL; HDL-C <40 mg/dL in men and <50 mg/dL in women; blood pressure ≥130/85 mmHg; fasting glucose ≥110 mg/dL.⁸

More Aggressive Guidelines for TG and HDL-C

While LDL-C lowering is recognized as the primary lipid target to reduce CHD morbidity and mortality, it does not remove all risk.⁹ Recent data has shed more light on the role of increased TG and decreased HDL-C in CHD risk. It is critical that these lipid abnormalities be considered and managed, in addition to LDL-C. In fact, the current National Cholesterol Education Program (NCEP) guidelines recommend more aggressive TG and HDL-C target goals.⁸ The American Heart Association (AHA) and American Diabetes Association (ADA) recommend similar aggressive goals for TG (<150 mg/dL) and HDL-C (>50 mg/dL) in CVD prevention for women.^{10,11}

You Can Help Make a Difference

A majority of women are still not aware of the substantial CHD risks posed by abnormal lipid levels.¹² As a physician, you can help make a difference by raising your female patients' awareness of these issues, and by helping them achieve optimal lipid levels, as recommended by the NCEP, the AHA and the ADA.

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