Electronic Health Records Put VA in Command

BY MARY ELLEN SCHNEIDER
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Over the last decade, health care within the Department of Veterans Affairs has transformed itself from a near failure to a national model for quality improvement, leaving many to ask how they could learn from 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 of the recipients were given a $100,000 grant to share the factors behind their success.

For Dr. Douglas J. Turner, it's clear that the VA is 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, straddles 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 several different electronic and paper sources to get the information he needs to see patients. In contrast, at the VA, every clinic is connected in the VistA system with a single patient identifier.

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, Dr. Turner said.

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.

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 in which 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.

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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 main lesson from the VA experience is that the system must be driven by the needs of the clinician, Ms. Fischetti said. It must also do more than replace the conventional paper chart. If the health IT product does not add value for physicians, she said, they might not adopt it.

She noted, however, that the VA, as both the payer and provider of health care services, distinguishes itself from most of the care providers in the United States. "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.

The system's success also depends on getting a return on investment—improvement in quality and cost-effectiveness of care—as seen in VistA.

These ideas are also applicable 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, he said, because recreating paper processes doesn't work. Physicians and administrators who are selecting an electronic health record system must let clinicians know up front that the work flow is going to change. ■