EHRs: Attitude isn't everything

As I read Dr. Kenneth G. Adler's article "Successful EHR Implementations: Attitude Is Everything" [November/December 2010, http://www.aafp.org/fpm/2010/1100/p9.html], I considered my own experience with electronic health record systems (EHRs). I've used three different systems and have always been committed to successful implementation, just as Dr. Adler recommends. After using one particular EHR for 18 months, I even spent over four hours with the vendor's representatives discussing useful and producible improvements that I believed were needed. The representatives listened intently, took notes and were very polite. In the following year, they implemented exactly zero of these improvements.

Vendors' most common excuse for not changing something simple is, "What if a different provider wants to arrange the problem list (or other feature) differently?" If they want users' suggestions, then they need to act on them or at least have a good reason why they won't. I feel somewhat displeased about paying $60,000 for a poor program and spending time trying to help the vendor improve it only to be charged for system updates that fix problems like bugs and logistical issues. As expensive as the updates are, you would think vendors could afford to pay us to help develop their products, not continually charge us for them. Adobe Photoshop is a much more elegant and sophisticated program, but it only costs $700. Why are EHRs so expensive?

These are the problems that make EHR software especially difficult to use:

First, many physicians recall producing – and many physicians still produce – paper-based documentation that includes, simply, diagnoses, treatment (frequently in shorthand) and any patient instructions, labs or other follow-up. This information can fit on a small sticky note. This approach has served physicians well for many years, so why don't EHR vendors take a similar approach? If I diagnose only "bronchitis," that means my eye exam is normal. If the eye exam isn't normal, I make the appropriate additional diagnosis. The EHR I use now requires that I document all normal findings because the software does not respond properly to the diagnosis or problems handled in the office visit. There is currently no EHR that performs in the manner that most physicians are used to. I heard somewhere that the software is supposed to be tailored to the user, not the other way around.

Another problem is that although my computer's word-processing software can correct as I type, mark misspelled words and expand my abbreviations on the fly (even my cell phone can pick "probable" words as I text), my EHR offers few, if any, of these standard word-processing features – and it costs 600 times as much.

And finally, wouldn't it be nice if physicians did not have to invest as much time up front preparing their EHRs to do things the way that most of us do them all the time? Instead, we receive these systems as blank slates – to allow us to specify one of the supposed infinite number of ways to describe each medication, each procedure, each follow up, etc. How many different ways can you write a sig for amlodipine? As far as I am aware, 99.5 percent or more of the time, it is written as 1 tablet, by mouth, once a day. Why not build in defaults with the option to make changes later so that we can get to work?

Richard Gibula, MD
Cottonwood, Ariz.

Controlled substance refill program: A sign of a broken health care system?

The article "A Proactive Approach to Controlled Substance Refills" [November/December 2010, http://www.aafp.org/fpm/2010/1100/p22.html] left me speechless. I realize that the vast majority of practices are organized in the same way as the authors' and that many practices likely find their advice useful. However, as I read, I found myself wondering, how are processes like these sustainable, and how exactly do they further patient-centered care? Why spend hours of unpaid time organizing a process that generates more unpaid work? And why would I divorce medication prescribing from provider interaction?

Articles like this one abound. One month an article describes a great way to teach diabetes care, and the next month it's how to make sure all six year olds have completed a school asthma action plan. Disease-oriented programs are everywhere, forcing physicians to run faster and faster to check off boxes in a system so fragmented that there are specific programs for specific problems.

In lieu of disease-specific care, I suggest patient-centered care. Physicians should consider managing their panel sizes so that they can offer improved access. When the patient needs a medication refill, the patient calls the office to make an appointment. The patient is seen that day, and

WE WANT TO HEAR FROM YOU

Send your comments to **fpmedit@aafp.org.** Submission of a letter will be construed as granting AAFP permission to publish the letter in any of its publications in any form. We cannot respond to all letters we receive. Those chosen for publication will be edited for length and style.

anything else the patient needs is taken care of then as well.

For me, efficiency means not wasting the patient's time. Patient-centered care puts the focus of "do today's work today" on the patient's needs, where they belong.

Jean Antonucci, MD
Farmington, Maine

Authors' response:

Dr. Antonucci's comments aptly capture the frustration that many of us feel about the lack of system and financial recognition of population-based and patient-centered care. "Doing today's work today" is a fabulous model to strive for. Unfortunately, in many clinical settings, ours included, the demand of underserved patient populations greatly exceeds the provider and resource supply.

As stated in our article, "In clinics with high demand or many part-time providers, monthly visits are not always possible." In such situations, managing panel size to offer open-access scheduling is not possible because patients cannot receive care elsewhere. As a result, innovative approaches to meet the patient's needs with high-quality, evidence-based medical care are needed. Group visits, nurse visits, ancillary visits and the use of trained lay educators are examples of such efforts we use to help meet the needs of our patients, despite the supply and demand mismatch. Our approach to controlled substance refills has been a successful model that allows unbiased, regular toxicology screening and provider oversight in the challenges of our environment.

We join Dr. Antonucci in looking forward to a health care system that provides access to everyone in a patient-centered, open-access model that makes our approach no longer needed.

Deanna R. Willis, MD, MBA, Gerald Eaton, BS, and Palmer MacKie, MD
Indianapolis

Change in Medicare annual wellness visit elements

After our January/February 2011 issue went to press, Medicare rescinded the "voluntary advance care planning" requirement for the new annual wellness visit benefit. The encounter form that was published along with our cover story, "What You Need to Know About the Medicare Preventive Services Expansion" [http://www.aafp.org/fpm/2011/0100/p22.html], has been revised to reflect this change. – *FPM* FPM