What a Community Cancer Center Can Learn from the Veterans Health Administration

by Lynn M. Jones, M.H.A., and Linda B. Gledhill, M.H.A

For years, physician offices and hospital outpatient departments have used technology to capture demographics, submit patient claim forms for payment, and track outstanding accounts receivable. Until recently, the Veterans Health Administration (VHA) was not allowed to bill for its services, so it concentrated on developing the electronic *clinical* record and making the records accessible to veterans wherever they live. Today, these electronic clinical records are accessible at all VHA facilities and can even be accessed at physician offices and hospitals outside of the VHA network. Because the VHA's computerized patient record system (CPRS) allows an easy flow of information between military and civilian providers, the CPRS has been a great benefit to people transitioning out of the military and back into the civilian health care system, as well as to patients who must go outside of the VHA network to receive treatment.

So, what lessons can a community cancer center learn from the VHA? Hospitals and physician offices that take a similar leap to a "paperless" system can realize a number of advantages, including cost-savings, a streamlined workflow, and improved clinical efficiency.

Get Involved and Communicate Your Needs

The VHA was actively involved in the development of its CPRS, and the result was a medical information system that is both comprehensive in nature and clinically friendly for its users. A community cancer center investing in a similar system would benefit from following the VHA example and being involved in the application development.

Off-the-shelf programs often do not include all the requirements your cancer program may need or want, but providing input and specific direction *before* the new system is implemented will ensure that you end up with a system that meets all of your needs. As you develop your system, keep in mind that oncology treatments and protocols differ dramatically from other specialties and require a customized approach to capture a patient's record accurately and completely. The VHA has taken into consideration the uniqueness and complexity of oncology patients as it develops its successful order entry and treatment tracking programs—*ChemoTrax* and *RadTrax*.

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Spend Money to Save Money

Even with the initial start-up investment, computerized patient record systems can offer a good return on investment *if* you choose the right system for your hospital or physician practice, stay involved with the implementation, and provide your staff with appropriate training

When the VHA converted to a computerized patient record system, it was able to immediately eliminate the costs associated with traditional paper records (i.e., storage and postage costs). Such systems can also save office space for your hospital or physician practice, allowing file rooms to be converted into additional exam rooms, patient education centers, or staff areas.

Submitting claims electronically allows your hospital or practice to review your claims *before* they are submitted, receive immediate error feedback, correct the errors, and resubmit without incurring the duplication of time and fixed cost. Not only are hard copy claims more time-consuming and expensive, they can take up to eight weeks to generate a notice of claim denial. By comparison, an electronic claim by Medicare is typically processed in 14 days.

Another cost-savings advantage of electronic medical information systems concerns malpractice premiums. Insurance companies have been known to reduce malpractice premiums by as much as 10 percent based on EMR use.[1] In cases where a malpractice suit is filed, the electronic documentation of patient progress and visits and a clear audit trail offers your hospital or physician office a strong defense.

Increase Your Operational Efficiency

In the past, VHA patients and staff were forced to go through the tedious and time-consuming process of transferring paper

records from location to location. The VHA's CPRS increased staff efficiency and created a seamless continuum of care throughout the VHA network.

Community cancer centers would receive similar benefits, albeit on a smaller scale. While your patients may not be moving across the country, they do go to many different departments within your hospital. Departments located on different floors or in a freestanding facility outside of the system can easily access electronic medical records, eliminating the time and effort staff spend physically locating and transporting the paper record. Even better, most EMR systems allow multiple staff members to view the electronic information at the same time. So, a radiation oncologist at a freestanding clinic and a medical oncologist at his or her private practice thirty minutes away can conduct a consult over the phone and both be looking at the most up-to-date patient information.

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Electronic medical information systems allow your staff to operate more efficiently. Staff can multitask more easily because they can switch from one task to another without interrupting the flow of each task and without having to physically get up and retrieve information from another location. Such systems also eliminate the need for staff to re-register patients every time they have a CT, lab work, or consults with a surgeon. Test and lab results, EKGs, and X-rays can be automatically entered into the system, reducing the risk of data entry errors carried out by hand and instances where information is left out because the paper documentation was lost or misplaced.

How Your Pharmacy Can Benefit

Prescription writing has been an area of much debate between physicians, pharmacists, and patients. Illegible writing on a prescription is inconvenient for both the pharmacist and the patient. The pharmacist must spend extra time deciphering the instructions and contacting the physician for clarification; the patient can face significant and inconvenient delays before the prescription can be filled. Even more alarming are the numerous instances where illegible prescriptions have resulted in patient injury and death.

Compared with other drugs, cancer drugs are some of the most expensive ones a physician orders, a pharmacy stocks, and a patient buys. Electronic prescription writing, a feature that is included in most electronic medical information systems, saves physician time and effort, acts as a safeguard, and reduces the cost of waste and error from physician ordered treatment drugs.

Computerized physician order entry (CPOE) systems are electronic prescription systems that integrate new electronic prescriptions with patient information, including laboratory, radiology, and other prescription data. The Leapfrog Group, a coalition of more than 140 public and private organizations that provide health care benefits, believes that CPOE systems help hospitals and physician practices reduce prescription errors, as well as save these organizations millions of dollars that would have been spent on litigation.[2] While CPOE systems can be expensive, a number of viable and more affordable prescription writing alternatives exist.

Whatever route your hospital or practice chooses, a fully integrated pharmacy program should offer:

- The ability to track past medications
- Drug interaction checks for current medications and adverse interaction checks for new medications
- Flexibility in prescribing medications
- Patient instructions that automatically print when medications are prescribed
- A method for tracking allergies and intolerances to medications
- The ability to easily renew all existing medications.

Other Considerations

The VHA system emphasizes the importance of the cancer registry for planning and resource allocation. Capturing this information electronically allows a community cancer center to track trends by diagnosis and demographics. This data can then be used to forecast future demands and needs, and can support research and capital expenditures.

The VHA's CPRS has also made complying with the Health Insurance Portability and Accountability Act much easier than it would have been under the old, paper system. Hospitals and physician practices can use medical information systems to restrict or grant access based on the job function of the staff member. Many systems offer audit trails that identify anyone who has accessed or added to the record.

We live in an age of technology where more and more individuals and organizations are seeing the benefits of going to electronic systems. Don't let your hospital or practice get left behind! Community cancer centers can take the lessons learned from the VHA as it developed its CPRS and use the information to develop a similar system that meets the unique needs of their oncology programs.

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References

[1]Expert System Applications, Inc. *The Advantages of an EMR.* Available at: *www.expert-system.com/emradvantages.htm*. Accessed June 26, 2003.
[2]The Leapfrog Group for Patient Safety. *Fact Sheet: Computer Physician Order Entry.* Available at: *www.leapfroggroup.org/FactSheets/CPOE_FactSheet.pdf*. Accessed June 26, 2003.

For More Information

Medical information technology systems and electronic medical records are featured in *ACCC's Essential Oncology Buyers & Resource Guide 2003*, which is bound in between pages 18 and 19 of this journal. Please see this comprehensive list of vendors and the article on pages 4–8 of the guide.