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TECHNOLOGY & MEDICINE

Harry's Homilies©

Harry L.S. Knopf, MD

ON SPECIALIZATION

dilettante versus Specialist:
one knows a little about a lot,
the other, a lot about a little.

Specialization is the thing these days. Everybody wants advice from the "specialist." Whether it be medicine, business, agriculture or law, there is always someone who is recognized as a "guru" – the "go-to" guy (or gal). They've "been there" and "done that." Does the dilettante have anything to offer here? Well, do you see an ENT specialist for a cold? Do you ask an MBA before you purchase a TV? Yes, I have exaggerated a bit, but you get my point: the person who knows a lot about a little may miss the "big picture." You must assess needs and then seek advice from the provider who best fits the problem.

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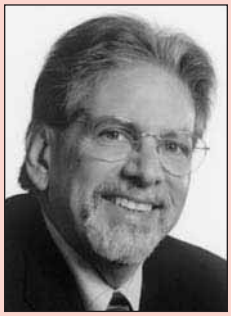
Dr. Knopf is editor of Harry's Homilies©. He is an ophthalmologist in private practice.

SCAM-Q*

** How insurance companies, hospitals, government, etc. Slice Costs And Maintain Quality*

Potpourri

By Richard J. Gimpelson, MD



Richard J. Gimpelson, MD

Everyone knows that potpourri is a mixture of flowers and essential oils that results in a very delightful aroma.

Well, my potpourri of medical issues will leave both a foul taste in your mouth and a foul smell in the air.

Twenty years ago, CLIA (the Clinical Laboratory Improvement Amendments) was passed because of a few cytology labs misreading Pap smears. The federal government, in its wisdom, decided to apply a tax on all physician offices even though none of these offices performed Pap smears. Thus, a continued tax has been paid by any physician who wants to do tests that a high school dropout could learn how to do in one to two hours or less. In addition, many tests primarily done in the office are now sent to outside labs at 5 to 10 times the cost.

Congress is still dragging its feet on resolving the Medicare pay costs. By the time this column is published, Congress will most likely offer a minimal increase in Medicare payments (one-half to one percent) to avoid immediate cuts of over 10 percent. The rumor is that the temporary fix will be for 18 months at which time if nothing is resolved, a 21 percent cut to physicians' pay will go into effect in 2010. If the fix is for only six months, it will not be a happy new year for many patients.

A recent report from AHRQ (U.S. Agency for Healthcare Research and Quality) shows a small improvement in quality of care for heart disease, cancer, and diabetes mellitus while at the same time demonstrating a large increase in costs for these conditions. I am confident that the improvement in quality is nearly 100 percent the results of work by physicians while the increased costs are almost totally the result of insurance companies, pharmaceutical companies, durable goods companies and the federal government. I draw this conclusion from the fact that physician incomes have gone down while all the others mentioned have increased their charges.

In summary: CLIA costs physicians and patients money without benefits.

Physicians are responsible for increased quality of care without any financial incentives.

Medicare will continue to create a huge problem with access to care unless physician payment increases.

You, Presidential candidates, better wake up and smell the coffee or potpourri; or there will be a medical care crisis that causes a lot more problems than the oil crisis.

Have a nice day!

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Dr. Gimpelson, a past president of SLMMS, is a gynecologist in private practice.

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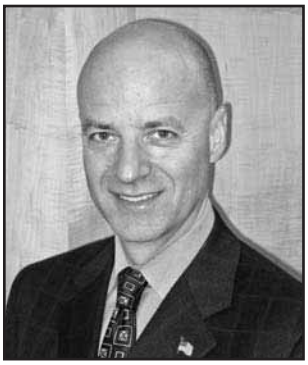
The advertisements, articles, and "Letters" appearing in ***St. Louis Metropolitan Medicine***, and the statements and opinions contained therein, are for the interest of its readers and do not represent the official position or endorsement of the St. Louis Metropolitan Medical Society. ***SLMM*** reserves the right to make the final decision on all content and advertisements.

The Non-Physician Practice of Medicine

Lay midwifery, cosmetic procedures and retail clinics raise concerns



Medical Society President George J. Hruza, MD, MBA

Over the past 100-plus years, physicians have been at the center of taking care of patients and advocating for patients. All states including Missouri have in place stringent licensure requirements as to who can practice medicine. Licensure has been established to protect the public from inadequately trained practitioners. The intensity of regulation, requirement for CME activities and board re-certifications of physicians has been rapidly escalating in the name of patient safety. However, just the opposite has been happening with regulation of non-physicians who want to practice medicine. Lay midwifery, cosmetic procedures and retail clinics are the latest examples of this troubling trend.

Lay Midwifery

Missouri used to have a sensible and safe way for women to deliver babies at home. Expectant mothers could have a certified nurse midwife attend their delivery secure in the knowledge that if anything went awry, the nurse midwife could call upon her collaborating obstetrician for assistance. Transfer to a hospital could then be promptly arranged. Last year, state Sen. John Loudon slipped one convoluted sentence into a comprehensive insurance bill without notifying his colleagues about it. The sentence stated that "…any person who holds a current tocological certification by an organization accredited by the National Organization for Competency Assurance (NOCA) may provide services as defined in 42 U.S.C. 1396 r-6(b)(4)(E)(ii)(I)." Translation: anyone who receives certification by a private entity (NOCA) is allowed to perform any services related to obstetrical care without any regulation or oversight by any government body. The required training/testing is up to the group, such as lay midwives or carpenters, that contracts with NOCA to certify their members. It can be as rigorous or as simple as the group being certified chooses. Obstetrical care includes prenatal care, epidural anesthesia, delivery, caesarian section and abortion. In effect, the bill makes obstetricians of anyone who so chooses without having to go through college, medical school, internship, residency, licensure or board certification. The bill passed and was signed by Gov. Matt Blunt.

SLMMS, MSMA, the Missouri Association of Osteopathic Physicians and Surgeons and the Missouri Academy of Family Physicians were initially able to get the provision voided as being unconstitutional as it was not related to the underlying bill to which it was originally attached. Attorney General Jay Nixon appealed the ruling to the Missouri Supreme Court. Unfortunately, the Court, in its infinite wisdom, determined that physicians do not have standing as they would not be adversely impacted by the law and reversed the lower court ruling. The decision was handed down after the deadline for anyone else to challenge the law had passed – very convenient. If physicians cannot stand up for their patients, who will? As the lay midwifery law now stands, it is open season on pregnant women in Missouri. There is no regulation, no supervision, uncertain training, and no need for liability insurance for lay midwifes. What happens if something goes wrong? Will the lay midwife be able to handle all birthing emergencies? Will the mother and/or baby have recourse to state government agencies or to the courts? Without the lay midwife having liability insurance, what attorney would take a botched delivery case? Does it make sense to turn the clock back 100 years to a time of far higher maternal and fetal mortality than we have today? Maybe the next step will be for barbers to lobby Senator Loudon to again be allowed to perform surgery as they did in the 1800s.

> **"As physicians, we should not stand idly by while our patients are put at risk."**

Cosmetic Procedures

Another area of concern is cosmetic procedures done outside the medical setting. Cosmetic surgery, especially the minimally invasive kind, has experienced exponential increase in demand. Where

there is great demand, there is money to be made. This accounts for the rapid proliferation of medispas. These spas are offering various laser treatments, Botox, fillers, peels, lipodissolve, etc., alongside facials waxing, pedicures, manicures and haircuts. The procedures are done by estheticians, cosmetologists, electrologists or nurses. The medical director, if there is one, is rarely on the premises. It is left up to the rest of the physician community to deal with the complications. I've had referrals of hypertrophic and keloidal scars after chemical peels to remove tattoos by an esthetician, infections requiring hospitalization after the use of the wrong laser at the wrong setting for tattoo fading, permanent depigmented patches after laser hair removal using the wrong settings and so on. The list gets longer by the day.

The Missouri Board of Healing Arts is silent on what, if any, physician supervision is needed for these "minimally" invasive procedures. The Missouri Legislature has, so far, chosen to ignore this growing threat to public safety. In 2005, a college student in North Carolina died after applying a compounded mixture of a topical anesthetic to her legs before laser hair removal at a medispa. North Carolina now requires close physician supervision of laser hair removal. What will it take before our board and legislature are ready to address this issue?

Retail Clinics

Walk-in clinics in Wal-Mart, Walgreens and other sites are cropping up all over with about 1,500 expected to be open by the end of this year. The clinics are staffed by nurse practitioners who have a collaborating agreement with an off-site physician. The clinics offer convenient hours and no appointments are necessary. They offer treatment for various everyday medical conditions such as UTI, URI and school physicals at a low cost. These clinics are popular with patients. Their financial viability is still up in the air with a number of clinics closing within the last 18 months. The key concerns are the risk of misdiagnosis, missed diagnosis and inappropriate steering to the pharmacy in the store where the clinic is located.

As physicians, we should not stand idly by while our patients are put at risk. Reversing the ill-advised lay midwifery law must be a top priority for organized medicine in the next legislative session. SLMMS has inaugurated a grim reaper award for the most egregious behavior by an insurance company. I recommend that Sen. Loudon be given a legislative grim reaper award for putting Missouri women and their unborn children at risk.

The Board of Healing Arts is in the process of developing a definition for what constitutes the practice of medicine. In the past, they were stymied in this effort by political pressure. Let's hope that this time around, they will be allowed to succeed. Once cosmetic procedures are clearly listed as being the practice of medicine, reasonable regulations for protecting patients can be promulgated without additional legislation. These should include direct physician supervision and provision of minimally invasive cosmetic procedures by properly trained allied health professionals such as nurses. If the board fails to act, then legislation with similar requirements will be necessary.

If retail clinics figure out how to make money, they will stay and proliferate. For physicians considering working with these clinics, it will be very important to consider the not-insignificant liability the physician takes on for patients they have never seen. If something goes wrong, a patient is far more likely to sue a doctor they have no personal relationship with than a doctor with whom they have good rapport. Most of the retail clinics are owned by corporations. In some states (Illinois), the corporate practice of medicine is not permitted. In Missouri, it is allowed and it is unlikely that the legislature would consider changing that. Instead, we need to encourage the Board of Healing Arts to keep a close eye on these clinics to make sure that patients are protected.

We have some formidable adversaries in our fight for patient safety. By staying involved, by putting patients first and by getting our patients involved we will prevail.

From the Executive Vice President

Magazine Provides Quality Service to Members

A look inside St. Louis Metropolitan Medicine

Medical Society Executive Vice President Thomas A. Watters, CAE

This month I would like to use the magazine to talk about … the magazine. It only seems appropriate.

Each month the inbox on my desk is continually buried in journals from a great number of metropolitan and state medical societies, as many of us exchange complimentary subscriptions so that we can stay in tune with what our contemporaries are doing. Some of them are excellent, many of them good, and a few not so good. In general, the state societies publish magazines of a higher quality than the regional and metro societies, but not always. There are a few excellent metro society journals, and my opinion – biased as it may be – is that ours is among those.

A primary difference between the journals of the state and metro journals is that the state journals place more emphasis on research and medical content. Metro societies, for the most part, don't try to compete with this objective, and view their journals more as an internal vehicle of communication for the members. The weaker ones, in my opinion, put too much emphasis on the latter. Striking an appropriate middle ground is our goal. Here in Missouri, *Missouri Medicine* is one of the finest state journals in the country, so we don't try to compete at the same level; we try to do something different.

A couple of years ago we transferred much of the responsibility for the publication of our journal to an outside source, i.e., using a consultant for much of the planning, writing, editing, and layout. I participate as well, along with an excellent publications committee and a number of members whom we depend on for regular contributions. (You can view the names of the committee members inside the front cover of every issue.) In particular, we owe thanks to Richard Gimpelson, MD, (SCAM-Q) and Harry Knopf, MD, (Harry's Homilies), who have been regular and dependable contributors for many years.

The ultimate, official responsibility for the magazine is always with the Council. The "unofficial" responsibility is mine, and it is one I take seriously. However, much of the day-to-day responsibility – most of it, in fact – belongs to Jim Braibish of Braibish Communications. He is responsible for much of our success and for the continuing excellence of our journal. Our successful quality control – making small, continuing improvements with every issue – is due to the great teamwork between him, our members and our staff. (Jim, by the way, is president this year of the Public Relations Society of America St. Louis Chapter and an excellent source of networking for us.)

> **"Each year we start with an editorial calendar which highlights a general theme for each issue"**

When we first moved much of the responsibility for the magazine outside of the office, it was done primarily for financial and logistical reasons. But it didn't take long for us to realize that in addition to positive financial benefits the overall quality of the publication was quickly improving. At this same time, we were making a transition from a monthly publication schedule to a bi-monthly schedule – again, as a financial measure. However, this also ultimately affected the quality of the publication. Instead of having to look for "filler" material every month, we quickly found ourselves with the pleasant task of having to eliminate less important copy in favor of priority items. This inevitably stepped up the quality of our content.

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Magazine Provides Quality Service to Members *(continued)*

In addition, we increased our efforts to sell advertising. Initially, there was a very real concern that going from twelve to six issues per year would cut our revenue in half. It wasn't realistic to believe we could just double our prices, so the only answer was to sell more. This we did. Last year, without a significant rate increase, we sold more advertising for six issues than we previously had ever sold for twelve. And, we have set a new sales record each of the last three issues and are on our way to a new annual record. Equally important, we only seek advertisers with a professional product of interest to our member physicians.

Most importantly, however, the *quality* of what we do continues to improve. One of the things I have been most proud of is that each year we start with an editorial calendar which highlights a general theme for each issue, and we work hard at building each issue around its theme. We don't attack each issue as a separate entity – we work on the entire year as one project, and are often thinking several issues ahead and collecting appropriate content. In this way, each issue is stronger and stays on task. We've added a significant amount of color, and have improved our layouts and overall look. It costs more, but with our increases in ad revenue we can afford it.

The goals of our magazine are simple. It is first and always our strongest vehicle of communication. We want to keep you informed abut the Medical Society, our seminars, conferences and various events as well as news about our members. We keep you aware of membership benefits and organizational business. You have the opportunity to hear from your peers and Society leaders through regular columns and featured articles. And, you hear about current trends and issues which affect medicine – technology and EMRs, practice management advice, public health issues and health-related service projects in the community. These are the goals of every issue.

You have a right to be proud of the magazine your Society provides you. Your dues help pay for it, and you deserve it. I hope you're sharing it with your staff, and with the patients in your waiting rooms. There's something in it for everybody.

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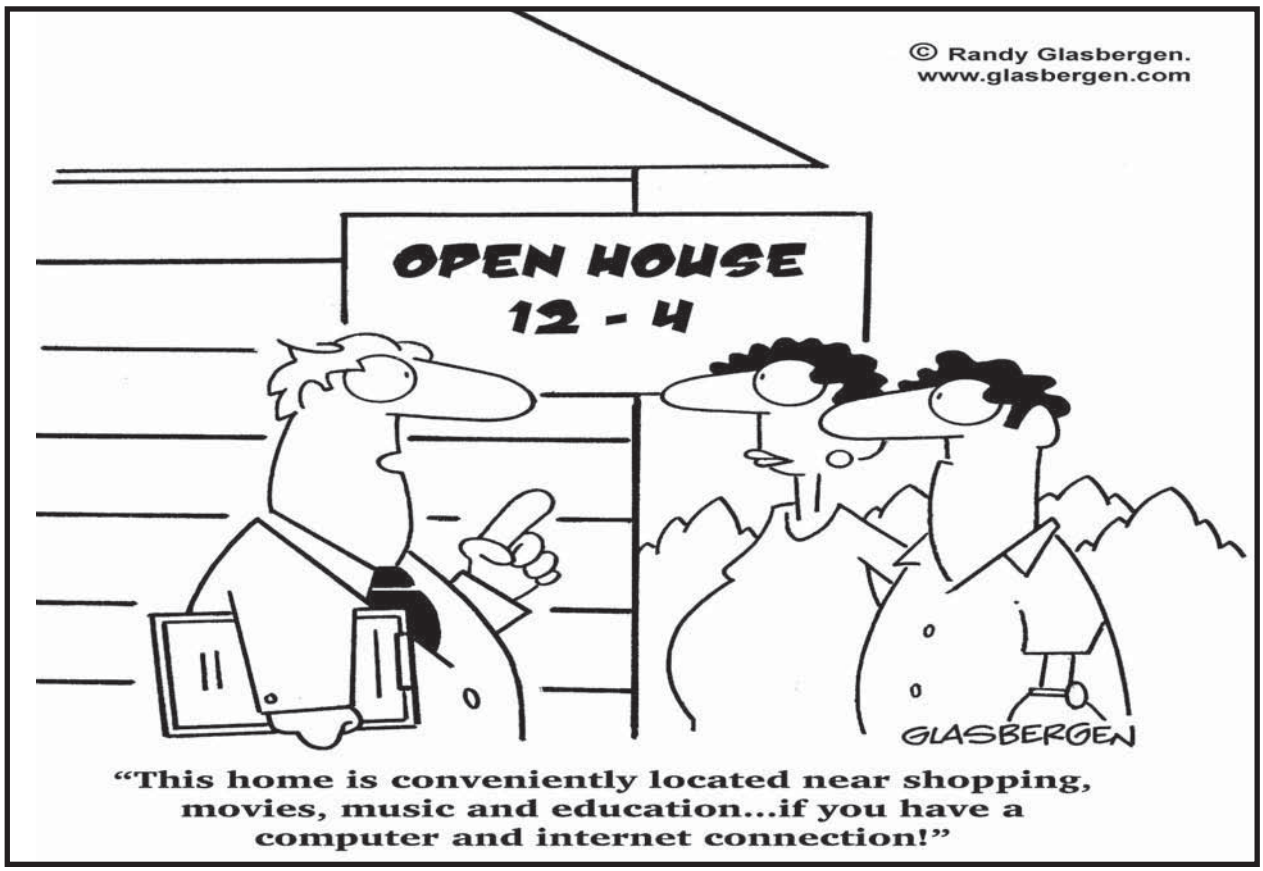

Selecting an Electronic Health Records System

Determine the level and function of the system that best suits your needs and budget

By Mark Anderson, CPHIMS, FHIMSS
CEO, and Healthcare IT Futurist, AC Group, Inc.

Mark Anderson, CPHMS, FHIMSS

Before you purchase a new EHR software application, you need to understand what type of EHR you really "need" and then determine the actual initial costs for the application, the ongoing costs for the application, and these hidden costs that practices have experienced during the last 24 months. To help understand the issues, the AC Group has created this paper on the different type of EHR applications. To view other white papers on such subjects as potential return on your EHR Investment (ROI), go to http://acgroup.org/research/whitepapers.html.

Introduction

Spending on technology by physicians has tripled since the 1990s and is expected to triple again in the next six years, according to an AC Group, Inc. study. It is anticipated that the average physician will spend up to $14,000 for an Electronic Health Record (EHR) software application and an additional $3,000 for other related third-party software. Additional hardware, networks and mobile devices could raise the level of spending for the average physician to $15,000 per year on technology. Although some of these additional costs may be offset by reductions in transcription, medical record storage, improved coding and charge capture, this still represents a significant additional initial and recurrent cost, particularly for small office practices.

When choosing a system, one should focus on the system itself, its features, feel, and perhaps most importantly, the track record of the software vendor. When comparing prices between vendors, one must make sure each vendor is offering comparable features and options. This task is one of the hardest for most physicians since there are almost 400 vendors stating that they sell the "best" product in the marketplace.

So Where Do I Begin?

First, with almost 400 EHR vendors in the marketplace, you need to decide what "type" of EHR you are looking for. Start by determining what level of functionality you really "need." Then determine how you want the product to interact with the administrative functions of your practice. Let's start with functionality. The following describe five different levels of EHR functionality.

→ **Level 1** – An EHR that allows the provider to scan documents into a file or a series of subfolders by patient name and/or number. The software also comes with the ability to record patient-related clinical information via voice dictation, typing, and handwriting following either a template design or a blank e-form by clinical category. No data integration with outside laboratories. No provider order entry and no auto results reporting. Software allows recording of evaluation and management (E&M) codes, but the E&M code is not suggested based on the data entered. Patient prescriptions can be printed, but there is no knowledge base for drug alerts and formulary compliance. The software does not provide point-of-care clinical decision support (CDS).

→ **Level 2** – An EHR that meets all of the requirements of level 1 plus the ability to capture patient family, social, and medical history using a defined format that can be shared with other practices as we move to common standards such as CCR and CCD. Software provides baseline tracking of orders and health maintenance alerts. Software provides lab ordering and results plus two-way orders and results reporting with specific laboratories. It checks for medical necessity, reviews health-care plans for ABN requirements and prints ABN if required. Ability to view lab results in a flow sheet over time and the ability to graph labs results over a period of time. Software provides baseline eRX charting of prior medication ordered by the health-service provider, ability to order new medications, and ability to print prescription in the office. No drug alerts are provided. Software provides baseline alerts and clinical support based on the EHR vendor's clinical databases.

→ **Level 3** – An EHR that meets all of the requirements of level 1 and 2 plus the software provides baseline charting with practice-specific clinical alerts. No national alerts or guidelines are required. Simple documentation following templates that can be modified by the practice and by the individual provider. Baseline orders and results reporting capability. Software provides patient summary page including the ability to review prior visit reasons, active medications, active lab results, next appoint-

ments, etc. Software provides advanced eRX documentation, drug alerts that are updated by the EHR vendor (no national standard alerts), and ability to electronically send prescriptions to specific pharmacies. Includes the medication history of client ordered by service provider AND other medical providers outside the clinic. Software provides advanced clinical orders capability based on national guidelines and follows medical necessity checking. System tracks all orders and indicates when an order result is past due. Software provides alerts and CDS plus advanced features based on specific customizable guidelines. Software provides advanced E&M, coding guidelines designed to ensure that the actual charges match the clinical charting.

→**Level 4** – An EHR that meets all of the requirements of levels 1 through 3 plus software providing advanced pre-built templates that can be customized by either the vendor or the practice based on specific practice requirements. Documentation follows national guidelines like CCD, SNOMED and CCHIT. Software provides advanced patient summary page plus strong health maintenance alerts, prior vitals, patient messages, chronic diseases and other patient specific information. Software provides advanced, practice customized two-way laboratory interfaces with such companies as Lab Corp and Quest along with order guidelines based on practice preference lists and patient condition. Results are automatically posted in patient chart and a note/message is sent to the provider/nurse based on practice-alerts guidelines. Software tracks all order tests and alerts practice if tests are not back within a specific timeline. Software provides advanced eRX with nationally updated drug alerts based on multi parameters, insurance-specific formulary compliance following companies like RXHub, pre-authorization alerts, and personalized eRX preference lists by provider. Ability to transmit eRX via SureScripts to the patient's preferred pharmacy. Software provides advanced orders and results based on practice guidelines and national best practices based on the patient's condition. Health-maintenance alerts are automatically provided based on patient conditions and orders are pre-identified based on national guidelines. Software provides advanced alerts and CDS based on national recognized sources that are updated on a routine basis. The alerts must include drug alerts, clinical best practices, health maintenance alerts, and disease-management guidelines. Software provides advanced charge capture for both nurses and physicians following the 1997 E&M coding requirements. System tracks the number of points per E&M coding category and provides the provider with a one-page summary of the appropriate E&M code.

→**Level 5** – An EHR that meets all of the requirements of levels 1 through 4 plus software providing advanced documentation; nationally recognized templates based on best practices, clinical guidelines, customizable to physician's practicing patterns. Product provides hyperlinks to outside clinical knowledge databases, problems are linked to orders. Ability to view summary information regarding the patient's conditions on one customizable screen. Documentation follows national guidelines such as CCR, SNOMED and CCHIT. Ability for patient to enter data via a kiosk or via on-line web-based personal health record. Patient Summary page plus the ability to customize the page based on the physician's and practice unique needs. Lab orders based on best practices and national guidelines. Receiving lab orders electronically, ability to have the data automatically posted in a flow sheet, ability to graph data results over time. Can visually compare lab results to eRX. Ability to combine results from dif-

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Is it Time for a Technology Checkup?

Review the security, availability and performance of your office computer network

By Ed Strode
AMD Technology Solutions, LLC

When is the last time your office had a technology checkup? Information on your patient medical history, your patient insurance and your accounting records are essential to running your practice. Most, if not all, of that information is stored and accessed from your computer network.

A regular checkup will give you the feedback you need to have confidence in the security, availability and performance of your computer network. Here are some functions to review with your information technology professional:

Security & Privacy

Start with HIPAA. While your software vendor may boast about their system's compliance, it is ultimately your responsibility to ensure that the information you have in your possession is cared for and shared within those HIPAA standards. A technology checkup will help to identify strengths as well any weaknesses in security or lack of security you currently have in place.

Another concern is unauthorized access from the outside world through an Internet connection. Not only can this cause havoc as a security breach, it also has the potential to jeopardize the integrity of your server as it co-exists with others on the Internet. A reliable firewall device that is configured properly can go a long way to cover any exposure to outside threats infiltrating your system through the connection to the Internet.

Security doesn't only apply to people on the outside trying to get in. The majority of security breaches initiate from inside your operation. Strong technology controls like strict password requirements and password expirations help to mitigate the risk of compromised data. Strong passwords are effective in keeping people from guessing or even advanced computer programs from determining your password to access information on your computer network. The expiration of passwords forces users to periodically change their password again to reduce the risk of security breaches.

The physical security of your computer network seems like it would be more obvious but it is often overlooked. If an employee remains logged in while leaving for lunch or even for the day, this provides an open invitation for an unauthorized person to peruse confidential data on your network. Other things as simple as privacy screens for monitors are often overlooked or deemed unnecessary, but you would be surprised what a nosey neighbor can glean from a computer screen during a 10-15 second stare. The costs to eliminate some of those risks are negligible or even free as a configuration option. Don't forget that convenient USB port can pose a security risk.

Information Availability & Reliability

Regular technology checkups can do wonders here, too. Whether you have adopted the use of EMR or not, access to patient information on the system at the time you need it is critical to the way your practice operates. Maximizing your time for better service to your patient is important. Maximizing the time of the practice staff needed to bill, receive and file claims is equally as important. The information on your system needs to be readily available to meet those demands.

Regular technology checkups can ensure that you have the tools in place to avoid costly downtime from viruses, botnets, spyware, etc. that often infiltrate computer networks. Those checkups can also help to make sure the hardware and software running your Practice Management System is kept up to date with patches and fixes that are released regularly by the manufacturers. When applied correctly, those patches and fixes can help to avoid untimely crashes and fix known security flaws within the existing configurations. These proactive actions ultimately increase the availability of information when you need it.

Access to information ***when*** you want it is important enough, but how important is it for you to access information from ***where*** you want it? Your other office, your home, a hospital, a hotel room on vacation or even your phone can all be possibilities to access your patient and practice information. Are all of those connection options available to you now and how reliable are they? Regular technology checkups can be used to discuss information access and make sure your access capabilities stay up with your demand for information.

Disaster Recovery

System disasters can make accessing your data impossible; larger disasters can wipe out an entire office or city blocks. How prepared are you to recover? A discussion of tolerance level for being without your information is a crucial one to have with your trusted technology partner. They would be able to help you with

both scenarios and to understand what is involved in recovering from each extreme. The reality of disaster possibilities and the preparation for recovery are important pieces of your overall practice planning and are not limited to your computer network.

Data Storage

Data storage is an area that should be monitored regularly as well. Regular technology checkups will also let you know how much data you are using now and how much room you have left for additional storage. This will be helpful in planning for system upgrades and enhancements as well as avoiding immediate problems by unexpectedly running out of space. EMR brings storage concerns to a whole new level as everything is maintained in digital form to be readily accessible.

Memory utilization and processor utilization are a couple of other areas that help a technology professional determine the performance and taxation of a computer network server. Identifying problems or taxation trends can help prevent slow or sluggish behavior from your network. Most technology professionals will also offer an automated monitoring and alerting service. A managed service like that will notify them when certain performance thresholds are exceeded so potential disaster or performance degradation can be avoided. Such a service is money well spent with a monthly or yearly fee that will allow for the 24-hour monitoring of critical components of your computer network. The early diagnoses of any problems discovered by the monitoring allow for a higher success rate in treatment and many times will avoid problems from developing all together.

Regular checkups are as good for your practice and your computer network as they are for your patients. The lifeblood of your practice is in the information stored and accessed on your computer network. The proactive approach to maintenance and upkeep can save hours of lost production, gigabytes of lost data, and thousands of lost dollars in recovery from disaster or litigation over a breach of security. Regular checkups will give you the feedback you need to have confidence in the security, availability and performance of your information systems. Your trusted technology partner can assist in creating a maintenance and wellness check that fits your unique needs. Remember, an ounce of prevention is worth a pound of cure.

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■ SLMMS Association Group Health Plans

■ Office Package

■ Workers Compensation

■ Surety Bonds

■ Automobile, Home & Umbrella

Matthew P. Reardon

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Selecting an Electronic Health Records System *(continued from page 17)*

ferent labs using the same format. Software provides advanced, nationally recognized, practice customized eRX with the ability to create customized preference lists based on the clinical findings of the patient. Ability for the patient to request eRX refills via secured web site. Ability to track when a patient does NOT pick up their medication from the pharmacy. Software provides advanced, nationally recognized, practice-customized advanced clinical orders and results reporting that are based on national best practices and nationally accepted standards. Orders are driven off of patient's condition, personal preference lists and advanced features. Software provides advanced, nationally recognized, practice-customized alerts and CDS that can meet all current and future guidelines via simplified advanced reporting or building of a new alert template. Software provides advanced, nationally recognized, practice-customized E&M coding tied to the patient's specific health-care plan for maximizing charge capture via pre-authorization alerts and guidelines. System provides advice in charge capture based on best practices and practice guidelines, and reports variances from guidelines. Software provides advanced, nationally recognized, practice customized clinical reference content with clear labeling of the levels of evidence for facts/assertions and grades of recommendation for recommendations made, and these levels and grades are clearly and transparently based on the quality of the underlying evidence using reproducible processes.

Conclusion

Start by determining what type of product you need today and will need in the future (three to five years out). Do not buy just for today, since many of the products are not designed for future needs that will occur when physicians are reimbursed based on P4P, clinical outcomes and disease management. Once you are down to the top five to eight vendors, ask each vendor to provide you with an estimated cost based on your organization. Ask them to provide you with an estimated three-year total cost of ownership. Once you receive the cost data, you will probably see a cost variation of two to four times depending on the selected vendors.

Once you have vendor pricing, you can then spend time with the top vendors determining which vendor best meets you specific needs. If you spend time looking at vendors before understanding the specific vendor's pricing methodology, you may find you cannot afford a vendor's solution, thus wasting your time and the vendor's time.

Mark Anderson spoke to the SLMMS Electronic Medical Records seminar in February. He can be contacted at (281) 413-5572 or mra@acgroup.org.

ad-vo-cate

\'ad-və-kət\ n
1. one that pleads the cause of another
2. one that defends or maintains a cause or proposal

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