An EHR Is Not always a Perfect Fit

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Amidst all the hoopla about electronic health records, Ken Beasley is sticking to his guns. When it comes to a conventional EHR, he says "thanks, but no thanks."

Instead, his group practice, Ortho Memphis, is using what he portrays as a "hybrid electronic medical record." The lower-cost option relies heavily on document imaging paired with doctors dictating notes for transcription.

And even if the federal government was to provide his practice with thousands of dollars worth of incentives to buy a conventional EHR, he wouldn't budge.

That's because Beasley, CEO of the 20-physician Tennessee practice, is steadfast in his belief that most conventional records systems get in the way of efficiently practicing medicine. So he won't use one, even as the practice expands to 31 physicians later this year.

"Where I've seen them implemented they've really slowed the doctors down," Beasley says. He argues that most of these systems are too cumbersome to use, requiring doctors to point-and-click on clunky templates or type in their notes. A far more efficient method, he contends, is to continue the age-old practice of doctors dictating notes for transcription.

Many records systems are so complex, he argues, that practices frequently use only a small fraction of their costly functions. He figures his practice saved several hundred thousand dollars by implementing a hybrid system from SRSsoft, Montvale, N.J., back in 2003, rather than a fully-functional EHR. And the hybrid system investment paid for itself in benefits in less than three years, thanks to a decline in support staff and elimination of storage space for paper records, among other factors, he adds.

To create a record of treatment, doctors scan a bar code on a paper patient information document using a reader attached to a digital dictation device. By scanning the bar code, basic information about the patient is tied to the recording. Physicians insert the device into a docking station several times each day. The digital files are transmitted to a central business office. Then transcriptionists type up the notes within 48 hours or less using a system from MedWrite Inc., Anaheim, Calif., and import them into the SRSsoft hybrid record.

Also included in the hybrid record are scanned images of test results, insurance cards and a wide variety of other forms, all organized by tabs. The system also automatically picks up detailed demographic information through a link to the group's practice management system.

Doctors also can use the hybrid record to create a prescription or place an order for a test as well as look up test results and medication histories. Prescriptions are either printed for the patient or faxed to a pharmacy.

Doctors can access the records system either at central workstations or in exam rooms via PCs. They also can access records remotely from their homes or hospitals using a virtual private network.

Some physicians print out a record of the most recent previous visit before seeing a patient. Otherwise, the practice has virtually no paper records.

Rather than view diagnostic images through the SRSsoft system, the practice has chosen to simply link the system to its PACS, from Stryker Corp., Kalamazoo, Mich. That way, doctors can easily toggle back and forth between the two systems when they want to view an image, Beasley says.

As a result of the more thorough documentation of treatment, the practice has earned a discount on its malpractice premiums from State Volunteer Mutual Insurance Co., Brentwood, Tenn., the CEO says. "A lot of people think that traditional records systems are the panacea," Beasley says. But he contends that for his practice - and many others - a hybrid approach that relies heavily on dictated records and scanned documents is far more pragmatic. And he's hopeful that any federal incentives will apply to hybrid systems.

"We've made the right decision," the CEO says. "This works for us."

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