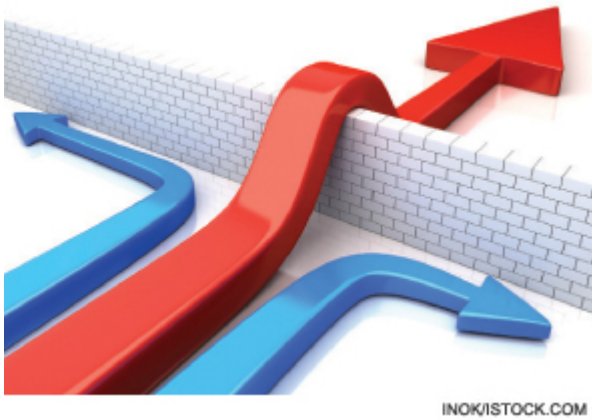


[ENT Today](#)



A Better Way to Implement EMRs: Why one-size-fits-all won't work

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by K.J. Lee, MD

I have been a strong advocate of electronic medical records (EMRs) for almost a decade. In fact, I used the phrases "It is the silver bullet for health care reform infrastructure" and "It is the cornerstone for health care reform infrastructure" to describe EMR plans when President Obama was campaigning. However, technology, like fire, can warm your house or burn it down, cook your food or kill you. Likewise, the wrong EMR will escalate inefficiency and raise health care costs. The wrong mandates or the wrong incentives have the potential to paralyze the day-to-day practice of medicine.

The current proposed meaningful use criteria are taken almost verbatim from the last administration. In a nutshell, the meaningful use criteria could be used to decide the amount of stimulus money each doctor will receive from the Centers for Medicare and Medicaid Services (CMS). The proposed criteria are good for managing chronic diseases and perhaps for in-patient hospital records, but will stifle and paralyze the diagnosis and treatment of the millions of acute diseases such as sinusitis, conjunctivitis and ear infections.

Hence, I propose that there should be a set of criteria for in-patient EMRs, another set for managing chronic diseases and a third set for managing out-patient acute diseases. It cannot be one-size-fits-all. It is crucial that each module be able to import and export clinical data from and to the other EMRs. Today's technology can achieve this. This exchange of clinical information will be greatly enhanced if each patient has a secured unique health care number (PIN), just as each doctor has a unique National Provider Identifier (NPI) number.

Providers who treat acute diseases need to digitally and efficiently document symptoms, physical findings, test results, prescriptions and treatment plans, but should not have to deal with entering over 50 data points for each visit, such as weight, height and BMI. These numerous data points are appropriate only for managing chronic diseases such as obesity, diabetes and cardiac problems. In addition, forcing doctors who treat acute diseases to enter these unnecessary data points will distract them from the patient and the illness at hand. Further, patients will get annoyed if a visit for conjunctivitis or external otitis must always include a discussion of weight, body fat ratios and cholesterol levels.

The Obama administration's current proposal requires doctors to prescribe not necessarily the best medicine but, rather, one that is in the patient's health plan formulary. Within each insurance company, there are many different health plans, depending on the premium paid by the patient. The health plan formulary changes every now and then, unbeknownst to doctors. In addition, the health plan formulary is based on obtaining the least expensive drug, not necessarily the best drug for the problem. The proposal will require doctors to shop for the least expensive generic drugs. I don't think patients want their doctors to be "shopping around," distracted from concentrating on the illness, making the right diagnosis and

formulating the best treatment plan. The pharmacy industry already has such a system. There is no reason to reinvent the wheel, which will just increase health care costs.

E-prescribing should mean that after checking for a drug allergy, the doctor is able to transmit the prescription electronically or fax the prescription to the pharmacy. If need be, the existing pharmacy computer system could check formularies and shop for less expensive alternative drugs. As a matter of fact, if checking formularies and shopping around are intended to save the insurance company money, then the insurance company should take the time and responsibility for this step.

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