



Health Information Technology  
Practice Management Services

## Joseph Perkinson, MD

- Victoria, Texas
- Solo practice
- *Specialty:* Family medicine

### Case Study: *Small Town Success*

For Joseph Perkinson, MD, a Victoria-based physician with a solo family medicine practice, using an EMR has been his way of knowing that he is making a difference for his patients. Dr. Perkinson entered practice in 1998 as an employed physician in a small town near Victoria. In a practice with “lots of paper and lots of patients,” he felt unsure whether his care really met the health care needs of his patients. When he moved to Victoria and opened his own practice in January 2001, he acquired an EMR so that he would be able to base medical judgments on a more complete view of the relevant data and see from the record whether patients were, in fact, benefiting from his care.

He cites the example of a patient with a higher-than-normal blood pressure reading. In a practice with paper records, the physician can flip through the record and view only the patient’s blood pressure at one or two previous visits. In a practice with an EMR, the record includes a graph of previous readings that indicates the trend of the patient’s blood pressure over time. “That’s what you really need to decide whether the patient needs medication or a change of medication or no medication at all,” Dr. Perkinson said.

He does not consider himself an “early adopter” of EMRs; those were the physicians who began using EMRs in the 1980s and early 1990s. He also does not consider himself a tech person. But a physician in solo practice located in a smaller community venturing into an EMR in 2001 had to be more than a little adventurous. There were no all-in-one software suites to integrate EMR functionalities with one another and with practice management systems. Moreover, the majority of vendors had little or no interest in selling and servicing physicians outside of metropolitan areas.

His selection of his practice’s EMR was based largely on two factors:

1. The availability of local support and
2. His strong preference for a Windows-based system.

The system Dr. Perkinson assembled required a custom interface to link the EMR to the practice management system so that the two could share patient demographics. He has since made additions to his system that include voice-recognition software; a blood pressure, pulse, and respiration monitor that records its readings directly into the EMR; and a software suite that allows patients to enter and update data from a computer in a kiosk in the waiting room.

From his experience with EMRs, he has three pieces of advice for physicians who are just beginning the process of introducing HIT into their practices. First, he is a strong believer in “best-of-breed” solutions in which physicians create systems that combine the best products from different developers instead of using

the suite approach in which the physician is committed to the products of a single developer. He states that “best of breed” results in higher quality, and although the up-front expenses may well be higher than simply adding another module to your current system, a customized solution is likely to have more enduring usefulness. Moreover, Dr. Perkinson is skeptical about the ability of practices to transfer their data easily from an integrated HIT software suite to alternative software. Once a practice has entrusted its data to an all-in-one system, the practice becomes dependent on the developer’s products and future upgrades.

Second, he sees the greatest barrier to HIT adoption as the physician perception that EMR use will slow the pace of physician work. He urges physicians to base their HIT adoption plans on the longer term benefits the technology provides. “Of course, EMRs do slow down physician work at first,” he says. But that early phase passes quickly, and what he found over time was that his efficiency has improved, the efficiency of his employees has improved remarkably, and that he has at his disposal a powerful tool for self-assessment and quality improvement.

Third, he strongly believes that physicians should acquire HIT primarily with the goal of improving quality of care. He acknowledges that there may be economic benefits, particularly with recent declines in the cost of the software. But the ability to have the relevant patient information immediately available as medical decision making takes place is clearly his most important objective. In his view, the availability of EMRs in physician practices is exciting and will bring about “a renaissance” in medicine.

Dr. Perkinson was able to recover the cost of his system in about three years. Because he knew when he opened his practice that he planned to acquire HIT, he hired only staff who had previous experience working with computers, although not necessarily with HIT systems. A trainer worked with the practice for a day, then staff worked on their own, simulating the day-to-day tasks of using the system. When the patients arrived, the practice was ready, and although an additional day with the trainer had been scheduled, it was cancelled as unnecessary.

The introduction of HIT has made a considerable difference in staff productivity. Time spent on moving charts around, handling prescription renewals, arranging MRI scans, and copying and sending medical records has all declined sharply. Dr. Perkinson uses a fax server to transmit prescriptions directly to pharmacies and to send or receive patient-related documents. He does not have secure e-mail. If patients want to communicate with him via e-mail he explains to them that he cannot ensure the confidentiality of their messages and will not reply to them via e-mail.

Technical support has been very strong. Dr. Perkinson gives his vendor high marks for the quality of service that his solo practice receives: “I’m just peanuts to them, but they never treat me that way.”