The Electronic Health Record in Private Practice

A choice
or
Just putting off the Inevitable

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Why the EHR?

• Medical care getting more complex.
• New information overwhelming physicians’ capacity to treat patients with latest information.
• New technologies are needed to help cope.
• The EHR is that tool that answers that need, and leads to better treatment for patients through new functionality and new services.
History of the EHR

- The concept of recording patient information electronically began in the late 1960’s.
- Larry Reed introduced the concept of the Problem-Oriented Medical Record. (See Appendix A)
- Goal was to generate a record that would allow a third party to verify diagnoses.
- 1972: Regenstreich Institute, a private, non-profit research organization affiliated with Indiana State University School of Medicine developed the first medical records system.
- Physicians, however, did not show much enthusiasm for the concept despite it being hailed as a major advance in medical practice.
Component Parts of the EHR

- Scheduling module
- Patient Registration module
- Documentation of Patient Encounter
- Writing Prescriptions
- Managing Documents
- Requisitioning/receiving lab and diagnostic imaging reports
- Managing interoffice communications
- Clinical decision support
- Billing
Benefits of the EHR

- Accurate and complete information about a patient’s health.
- The ability to quickly provide care.
- The ability to better coordinate the care physicians give.
- A way to share information with patients and their family caregivers.
- Improve the quality and convenience of patient care.
Benefits of the EHR, continued

• Increase patient participation in their care.
• Increase accuracy of diagnoses and health outcomes.
• Improve care coordination.
• Increase practice efficiencies and cost savings.
• Reduce transcription costs.
• Reduced chart pull, storage, and re-filing costs.
Benefits of the EHR, continued

• Improved and more accurate reimbursement coding with improved documentation for highly compensated codes.
• Reduced medical errors through better access to patient data and error prevention alerts.
• Improved patient health/quality of care through better disease management and patient education.
Benefits of the EHR, continued

• Easy access to patient information from anywhere.
• Tracking electronic messages to staff, other clinicians, hospitals, labs, etc.
• Automated formulary checks by health plans.
• Order and receipt of lab tests and diagnostic images.
• Links to public health systems such as registries and communicable disease databases.
Challenges of the EHR

• Cost, start-up.
• Cost, maintenance.
• Considerable time spent in system management to get each individual user set up properly.
• Considerable time spent to train staff.
• Change/disruption of office routine and activity.
Challenges of the EHR, continued

• Existing workflows and issues related to proper data entry protocols require workflow redesign and implementation.

• Integration, while positive in general, creates its own issues....i.e. incorrect registration creates negative impacts for billing and the ability to drop a bill.
The EHR Stimulus

• Government funding is available to physicians who qualify...
• Under ARRA (American Recovery and Reinvestment Act)
• Non-hospital based physicians who participate in Medicare or derive 30% or more of their business from Medicaid are eligible to receive subsidies.
• Maximum amounts range from Medicare payments of $44,000 to nearly $64,000 for Medicaid over a 5-year period. Those who apply in 2013 receive $15,000 in the initial year, and followed by 3 years of diminished payments. After 2016, there will be no payouts.
Requirements for the Stimulus

• The Medicare/Medicaid EHR Incentive Programs are given to those providers who demonstrate the “meaningful use” of certified EHR technology to improve patient care.

• “Meaningful Use” requirements are segmented into 3 time-dictated stages:
  – Stage 1: 2011 – 2012
  – Stage 2: 2014
  – Stage 3: 2016
Stage 1

• Electronically capturing health information in a standard format.
• Using that information to track key clinical conditions.
• Communicating that information for care coordination processes.
• Initializing the reporting of clinical quality measures and public health information.
• Using information to engage patients and their families in their care.
Stage 2

- More rigorous health information exchange. (HIE)
- Increased requirements for e-prescribing and incorporating lab results.
- Electric transmission of patient care summaries across multiple settings.
- More patient-controlled data.
Stage 3

• Improving quality, safety, and efficiency leading to improved health outcomes.
• Decision support for national high-priority conditions.
• Patient access to self-management tools.
• Access to comprehensive patient data through patient-centered HIE.
• Improving population health.
Steps in EHR Implementation

• Assess your Practice readiness.
• Plan your approach.
• Select or Upgrade to a Certified EHR.
• Conduct Training and Implement an EHR system.
• Achieve “Meaningful Use”.
Assess your Practice Readiness

• Conduct an assessment of your current practice and its goals, needs, and financial/technical readiness. You can then design an implementation plan that meets the specific needs of your practice.
Plan Your Approach

• Draw on the information gained during Step 1, the assessment of the specific needs of your practice to outline your EHR implementation plan.
Select or Upgrade to a Certified EHR

• Review the current CMS-approved list of Certified EHR software vendors.
Conduct Training and Implementation of an EHR System

• Implementation involves the installation of the chosen certified EHR system and associated activities...
  – Training of staff
  – Mock go-live
  – Pilot testing
Achieve “Meaningful Use”

• Please refer to section “Requirements for the Stimulus”.
Penalties for EHR Non-use

• There are penalties for those providers choosing not to engage the EHR after 2014:
  – 2016  Loss of 1% of Medicare reimbursement.
  – 2017  Loss of 2% of Medicare reimbursement.

Thereafter and each year thereafter: Loss of 3% of Medicare reimbursement.
The Choice is Yours

• Prepare now, or risk losing reimbursement dollars from your ever-growing Medicare population.
Appendix A

• Larry Reed was, in fact, Dr. Lawrence L. Reed, a New Hampshire physician in the early 1970’s.
• He conceptualized the Problem Oriented Medical Record. (POMR)
• His concept intended that a modern medical record provide a unified approach that would make for consistency and ready dissemination of information in a standardized format.
Dr. Reed’s SOAP Record

• The SOAP Record was innovative in that it organized the various factors of a medical encounter:

• S  Subjective factors
• O  Objective findings
• A  Assessment
• P  Plan