EMR Success Varies With Size of Cardiology Practice

BY CHRISTINE KILGORE
Contributing Writer

WASHINGTON — The introduction of a customized electronic medical record system in a multisite practice of heart specialists enhanced efficiency and the quality of care that the patients received, said Dr. Vince Bufalino in a presentation at the Heart IT Summit.

Dr. Bufalino, who came to the summit from the 55-physician multisite Midwest Heart Specialists practice in suburban Chicago, reported on a host of improved outcomes that the practice has documented since it developed an electronic medical record (EMR) system in 1997.

He detailed improvements in the numbers of patients achieving LDL cholesterol goals and the numbers of coronary artery disease and heart failure patients taking recommended drugs, and more. In addition, he said, the customized EMR system "has made us more efficient" and "it practices the way we practice."

The summit, sponsored by the American Heart Association, American Stroke Association, the Agency for Healthcare Research and Quality in coordination with the Office of the National Coordinator for Health Information Technology, was devised to "develop a road map" for using IT to improve the quality of care for patients with cardiovascular disease and stroke. Each organization went home with a list of potential strategies developed by break-out groups focusing on clinical practice, research, and patients.

However, Robert Miller, Ph.D., who reported on electronic happenings in solo and small group practices, said of the 14 primary care practices he and his associates studied, only 2 had extensively used their electronic medical record systems to improve chronic and preventive care.

Dr. Miller, of the University of California, San Francisco, said practice support services and performance incentives that are tied to quality improvement are "musts" for increasing the "value for all" of EMRs in smaller practices. Overall, the physicians in his study saw substantial revenue gains from EMRs: an average of $33,000 per full-time provider per year after an average "pay-back time" of 2.5 years. Almost all of that gain came from increased coding levels and efficiency-related gains—results that are a good value for many practices but "not a good value for payers" or even patients, he said.

The differences between the large IT leaders and the small- to medium-sized practices that are attempting to build electronic systems—or still rejecting them—were the cruxes of the summit.

"We all know the quality benefits of the EMR" from the larger practices, "But how do we actually roll it out on a larger scale?" said Dr. Rose Marie Robertson, chief science officer of the American Heart Association. The problem is that little is known about how off-the-shelf systems are working in everyday practice and about what nontechnical factors, such as organizational and human factors, are necessary to sustain electronic systems, she and other physicians at the meeting said.

Suggested strategies included improving and standardizing decision support tools, developing fiscal and nonfiscal incentives for using EMRs, sharing best practices, and collaborating on developing standardized clinical nomenclature and interoperable systems. ■

A Step-by-Step Approach Will Ease the Shift to EMRs

BY JOYCE FRIEDEN
Associate Editor, Practice Trends

WASHINGTON — Physicians who are too nervous to completely convert their offices to electronic medical records can start the process with a few "baby steps" to make it less intimidating, Dr. Daniel Sands said at a health care congress sponsored by the Wall Street Journal and CNBC.

Physicians are often reluctant to leap into an EMR system because of its complexity and the expense involved, said Dr. Sands, of Harvard University, Boston. "If you're a doctor, what do you do? How do you get that [EMR] if you can't take the one big leap?"

One way to start is by using electronic communications with patients and with office staff, he said. "Why don't you get rid of those stupid yellow Post-It notes you use for phone messages? A simple step like that is a good way to get people engaged with technology."

Electronic prescribing is another way to bridge the gap, said Dr. Sands, who is also chief medical officer of ZixCorp, a Newton, Mass., company that sells electronic prescribing software. Medications can be prescribed using various electronic devices, including desktop and laptop computers, handhelds, and even mobile phones. Since studies have shown that electronic prescribing can reduce medication errors substantially, "this should be the standard of care," he said.

Another baby step is to use online clinical reference materials, Dr. Sands said. "We have lots of data showing physicians are often faced with questions when taking care of patients, and they can't find the answers because they don't have time, so they just move on. And that's really scary."

Rather than looking for answers "in a book that's out of date as soon as it's printed, maybe looking online would be a great place to start," Dr. Sands said. ■

Goals Set for Making Electronic Health Records More Accessible

BY MARY ELLEN SCHNEIDER
Senior Writer

Over the next year or so, leaders in the health information technology community will work on ways to make medication history and some general demographic information available to consumers in a portable health record.

Experts at a Webcast meeting of the American Health Information Community agreed that this is the "low-hanging fruit" that could eventually pave the way for widespread access to portable, consumer-controlled personal health records. The American Health Information Community is an advisory committee to the Department of Health and Human Services.

The development of portable electronic demographic information, or registration information, would be a way to do away with the medical clipboard, HHS Secretary Mike Leavitt said.

"The timeliness of access to medical information is critical to patients," said Nancy Davenport-Ennis, CEO of the National Patient Advocate Foundation and a member of the American Health Information Community. Today, most patients feel they own their medical record but when they go to get lab results from their physician, it can often take days or weeks, she said.

One of the major hurdles in creating secure and portable patient health records is authentications, said Dr. Reed Tuckson of UnitedHealth Group, who presented information to the group. Others include the inability to locate patient information across multiple settings, segmentation of the consumer market, privacy concerns, low levels of consumer trust, few electronic health records to connect to, and the lack of an established business model.

But there have been some successes, said David Lansky, Ph.D., of the Markle Foundation, who presented information to the group. For example, the Department of Veterans Affairs set up a patient portal, and the Department of Defense has a similar program. And some health plans offer pre-populated personal health records. "We're not starting with a blank slate."

Providing medication history electronically to patients is something that could be done quickly, he said. The Markle Foundation helped spearhead efforts to do just that with www.katrinahealth.org, which allowed certain physicians to access drug histories for hurricane evacuees.

It's helpful that the public already recognizes the value of using this type of information in emergencies, Dr. Lansky said.

Providing electronic access to general demographic data or registration information holds the potential for increasing convenience for patients and improving accuracy when sharing information. But privacy issues would need to be addressed and there is the potential for replicating errors, he said. ■

Medicare Audit Policy Is Questioned

WASHINGTON — Medicare is all about overpayments, but underpayments? Not so much.

Members of the Practicing Physician Advisory Council wanted to know why a new demonstration program from the Centers for Medicare and Medicaid Services rewards contractors financially for finding money owed to the Medicare program, but not for finding money that Medicare has underpaid to physicians.

Under the program, known as the Recovery Audit Contractors program, three contractors hired by CMS look for overpayments and underpayments made by Medicare to physicians and hospitals, and try to recover the overpayments.

The program, which began last spring, operates in the three states with the largest Medicare beneficiary populations: California, Florida, and New York. Contractors review claims of at least a year old.

Contractors are paid a percentage of what they collect in overpayments, but there is no similar incentive for finding underpayments. That's because Medicare would have to pay out more money than the amount of the underpayment, "and that's money going out of the [Medicare] trust fund," Gerald Walters, director of the financial services group at CMS, told PPAC members at a council meeting. He said CMS "believes it has found a way to incentivize" the contractors to target underpayments, but he did not elaborate.

—Joyce Frieden

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