Customization, Involvement Key to EMR Success

BY MARY ELLEN SCHNEIDER
Senior Writer

Successful implementation of an electronic medical record system to improve quality requires attention and effort from physicians at the beginning of the process, according to experts.

The more time physicians spend up front customizing the system to fit their needs, the less they will struggle later on, said Dr. Barry Bershow, director of quality and informatics at Fairview Health Services in Minnesota.

Dr. Bershow has seen first hand how effective electronic medical record tools can improve quality. At Fairview Health Services, which includes hospital and clinics across Minnesota, there has been significant improvement in quality measures in recent years. For example, screening for chlamydia has nearly doubled from 2004 to 2005, and there have been dramatic improvements in asthma management and obesity screening.

Electronic medical records can also improve quality within small practices, he said. Before coming to work for the Fairview system 2 years ago, Dr. Bershow spent about 28 years working in a small family medicine practice affiliated with the Fairview system. In 1999, the practice became a pilot site to test Fairview's electronic medical record. The implementation proved successful, and the practice continues to use the system today.

Implemention of the EMR system led to reduction of staff by approximately four full-time employees and to improvements in quality, particularly in coronary artery disease and diabetes care, Dr. Bershow said.

"It wasn't just because we were really good doctors," he said. In fact, the performance improvements they saw were in areas where the EMR included clinical decision support and other prompts.

But Dr. Bershow doesn't downplay the tough transition to the system. He said it took 3 months before the physicians in the practice could start to go home at the same time they did before implementation. But at 6 months, half of the physicians were going home earlier than before, he said.

In the first couple of months, physician and staff satisfaction dropped, according to satisfaction surveys, he said. At that point the excitement was gone, and they had yet to realize the benefits, Dr. Bershow said. But at 4-6 months, patients started coming in for return visits, and staff began to see efficiency in the system. At 6 months, all the results had improved including patient satisfaction, he said.

One common mistake that physicians make is not building in the shortcuts at the beginning, Dr. Bershow said.

Implemention of an electronic health record is not a guarantee of improved quality. In fact, a qualitative look at one suburban family medicine practice shows that a lack of communication about the goals of the EMR has actually led to a drop in quality improvement activities.

Jesse C. Crosson, Ph.D., of the New Jersey Medical School, Newark, and his colleagues, analyzed the EMR use of a family medicine practice in an upper middle-class suburban community in 2002

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AHRQ's Health IT Lessons Online

Officials at the Agency for Healthcare Research and Quality are putting out some of the lessons learned from their health information technology projects. The information is available on the ARHQ Web site—www.healthit.ahrq.gov.

The Web site includes some of the early lessons from AHRQ-funded projects in a range of settings including health plans, hospitals, and small practices. The site also features links to more than 5,000 health IT resources, an evaluation tool kit to help implement health IT projects, and funding information.

"Adoption of health IT will be too slow if providers have to reinvent the wheel one by one," AHRQ Director Dr. Carolyn Clancy said in a statement. "This shared learning tool brings the lessons of experience together in one place, so we can help providers avoid problems and achieve greater benefits when they make their move to health IT."

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with follow-up in 2003 (Ann. Fam. Med. 2005;3:307-11).

Dr. Crosson and his team found that before the implementation of the EMR, the practice had used reminder stickers on their paper charts for screening, prevention, and disease management. However, when the practice switched to an electronic system, the EMR's built-in reminders were disabled because they were too cumbersome, leaving the practice without any formal reminder system.

The lack of communication was a real obstacle in this practice, Dr. Crosson said in an interview. He recommended that physicians planning to implement an EMR sit down early on with a broad group of people within the practice to figure out how to maintain the existing quality of care system once the electronic system is in place. This could mean having duplicate systems in place during the transition period, he said.

One barrier to realizing the full potential of EMR systems is that physicians are trained to take care of one person at a time, Dr. Crosson said, and many of the innovative EMR functions help in caring for groups of patients. There needs to be a shift in the mind set of physicians in order to truly take advantage of the advances in technology, he said.

When shopping for an EMR that can aid in the collection and reporting of quality improvement measures, look for a system that can export the data in an electronic format, said Dr. David C. Kibbe, director of the American Academy of Family Physicians' Center for Health Information Technology.

Most EMRs today allow physicians to export clinical data electronically to a health plan or other third party. Some of the more expensive systems allow physicians to analyze their own data and produce reports on their performance. ■

OIG Report Spurs Consult Coding Scrutiny

BY MARY ELLEN SCHNEIDER
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PHILADELPHIA — Be careful how you code for consultations because Medicare contractors will be watching this area carefully, coding experts said at the annual meeting of the American College of Physicians.

In March, the Department of Health and Human Services Office of Inspector General (OIG) issued a report highlighting more than $1 billion in estimated overpayments made to physicians in 2001 for consultations under Medicare. In many cases, services were incorrectly billed as consultations, coded for the incorrect type or level of consultation, or were not supported by documentation, according to the OIG report.

OIG officials selected a random sample of 400 consultations allowed by Medicare during 2001, obtained photocopies of portions of patients' medical records, and hired certified professional coders to audit the claims. The results of that audit were extrapolated to produce the $1.1 billion overpayment estimate. Officials found the most problems with consultations billed at the highest billing level and with follow-up inpatient consultations, according to the OIG report.

Pay attention to the definition of and the elements involved in high-level consultation codes, advised Dr. Glenn D. Littenberg, chair of the ACP subcommittee on coding and reimbursement. He urged physicians to keep in mind that a level 5 consultation code involves an extended history of the present illness, a complete system review, a complete family social history, a comprehensive physical exam, and high-complexity decision making.

Complete documentation is essential and should include the request from the referral source, what services were provided by the physician, and the report back to the referral source, Dr. Littenberg said. "It's highly likely that based on [the OIG] report, carriers will be paying a little more attention to consultation coding at the high level," he said.

Officials at the Centers for Medicare and Medicaid Services have already made some changes in consultation coding this year. Beginning this year, CMS has eliminated the CPT codes for follow-up inpatient consultations (99261-99263) and confirmatory consultations or second opinions (99271-99275).

In the office setting, physicians can use the office or other outpatient consultation codes (99241-99245) for initial consults and the office or other established patient codes (99212-99215) for follow-up visits.

Consultations that are requested by the family or patient instead of a physician cannot be billed using consultation codes, according to CMS, and instead physicians should rely on existing E/M codes for the setting where the service is provided. ■

The OIG report is available online at www.oig.hhs.gov/oei/reports/oei-09-02-00030.pdf.