

# Workforce Needs for Physicians' Health Information Transformation

What Problem(s) Need Solving?  
Is Manpower the Appropriate Solution?

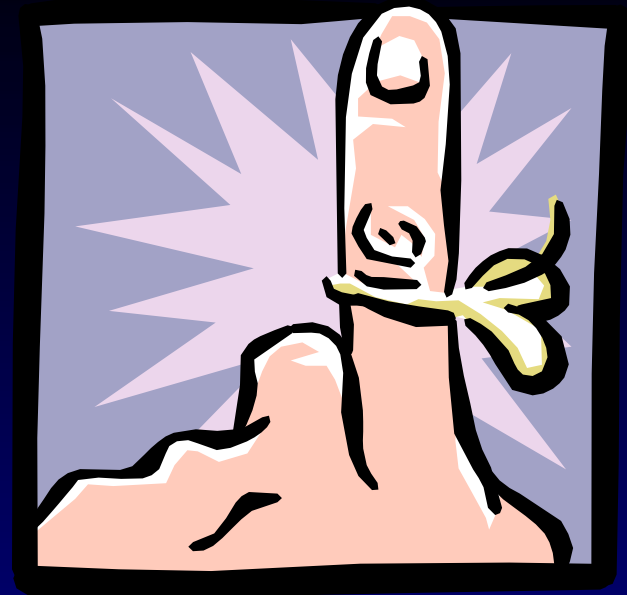
Stephen R. Levinson, M.D.

ASALLC@aol.com

[www.PracticalEM.com](http://www.PracticalEM.com)

# Disclaimer

- This presentation is designed to provide accurate and authoritative information in regard to the subject matter covered. The information includes both reporting and *interpretation* of materials in various publications, as well as *interpretation* of policies of various organizations. This information is subject to individual *interpretation* and to *changes over time*
- Presenter has personal interests in consulting, presenting, writing about, and developing software in order to help physicians achieve compliant medical records and to help them facilitate quality patient care



A computer monitor with a dark grey bezel and a black stand. The screen is white and displays two lines of text in a dark blue, serif font. The text is centered and reads: "Our goal for Electronic Health Records is to Create a Network of *Interconnected* Quality Medical Records".

Our goal for Electronic Health Records is to  
Create a Network of *Interconnected* Quality  
Medical Records

Realistic Manpower Needs Require that we Start  
with *Individual* Quality Medical Records

# AHIMA/AMIA Summit on Workforce

---

- “A workforce capable of innovating, implementing, & using health communications and information technology will be critical to healthcare’s success”
- “Conversely, without such a workforce, implementations will fail or could even cause harm”

# AHIMA/AMIA Summit on Workforce

- Two contingents in health information workforce:
- Health information specialists
  - “The need for specialists is growing, the # of trained specialists is not keeping pace”
- Those who use HIT and EHRs to perform their duties
  - “No systematic plan exists for training the members of the current healthcare workforce to use IT tools to do their jobs”

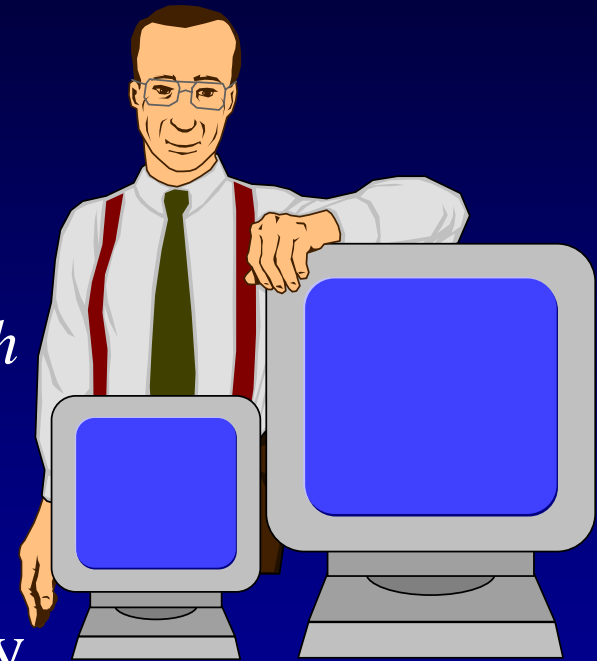
# EHR Workforce Needs Encompass a Broad Range of Considerations

---

- Variables include:
  - Size of practice
  - LAN vs. ASP model
  - Existing HI staff
  - *Incremental* workforce needs during implementation
  - *Incremental* workforce needs after implementation
- H.I. Specialist Needs
  - Project manager
  - IT interface builder
  - EHR implementation spec.
  - Database administrator
  - Network engineer
  - Privacy specialist
  - Security specialist
  - Trainer (especially for MD)
  - Help desk

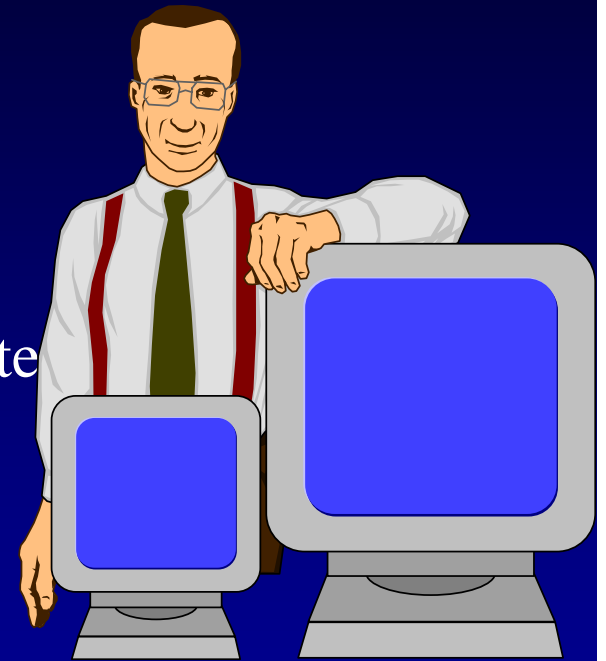
# What is the CORE Engine of All EHRs?

- “The EHR first has to work as a medical record”
  - *(before physicians concern themselves with interconnectivity, interoperability, and health information exchange)*
  - Dr. Joseph Heyman, (at eHI’s Connecting Communities Learning Forum, April 2006)
- i.e., physicians **MUST** have a high quality, compliant, usable & efficient H&P



# What is the CORE Engine of All EHRs?

- Who is creating standards & criteria for, and working to improve, the H&P component of EHRs?
  - At best, current CCHIT criteria are inadequate
    - Only 5 of 261 criteria for 2007 apply to H&P
    - All 5 are problematic (e.g., 1<sup>st</sup> & last)
  - At worst, they magnify the compliance & quality problems in physicians' existing paper records
    - ***Require*** provision of non-compliant design and functionality





# The Physicians' H&P - Truisms

---

- For quality medical care:
  - The H&P and medical record are integral to, & essential for, quality patient care:
  - Quality H&P is most powerful diagnostic tool in our armamentarium (not tests)
  - “With a good medical history, a physician can make the diagnosis 95% of the time before he (she) even picks up a stethoscope”
- For healthcare system & cost-effectiveness:
  - “By applying this history-centered paradigm, the provision of healthcare becomes more efficient, directed, and cost-effective”

# The Physicians' H&P - Truisms

- CPT's E/M system has been the standard for medical record compliance since 1/1/1992
  - Including its measure of “medical necessity”
- E/M compliance is based upon the standard text “Bates Guide to the Physical Exam & Medical Hx”
  - It is a *codification* of (and blueprint for) the standard of high quality medical care taught to student physicians;
  - i.e., E/M compliance is an effective model for *quality care*
- \* Therefore, it is reasonable and effective to require compliant E/M principles as the *standard* for the physicians' H&P component of EHRs

# The Physicians' H&P - Observations

- No medical schools or residency programs are currently providing training or effective tools to student physicians' for E/M compliant medical records
- Current board tests (part 2) certify students for performing “problem focused” (level 1) care!!!!
- Generally, current EHR systems have not incorporated *compliant* E/M principles (especially medical necessity), but most have incorporated *non-compliant* tools to speed documentation

# Where are We Now With H&P in Physicians' Paper Records?

---

- Audits of medical records consistently show:
  - 80% failure rate of E/M compliance
  - High probability of provision of “problem focused” care, even for patients whose illnesses warrant comprehensive care (according to physicians' own specialty society guidelines)

# Where are We Now With H&P in Electronic Records?

---

- “Forty percent of attempted (EHR) implementations fail”
  - (Dr. Mark McClellan, director of CMS, Sept. 9, 2005)
- Physicians implementing EHRs can anticipate a 20% - 30% decrease in productivity for 6 – 12 months
  - (Report of the Institute of Medicine)
- “For outpatient practices...approximately 90% of the financial benefit accrues to payers and purchasers, though physicians must make the investment”
  - (Ash J & Bates D, “Factors Affecting EHR System Adoption: Report of a 2004 ACMI Discussion,” J Am Med Inform Assoc, 2005)
- “The best HIT system in the world is only as good as its content”
  - (Dr. Carolyn Clancy, director of AHRQ, Sept. 9, 2005)

# Where are We Now With H&P in Electronic Records?

---

- Part B News article on ‘OIG Fraud Alert’ for EHRs, 5/06, reporting CMS concerns with the H&P component of EHRs:
  - Potential upcoding by EHR software “has attracted the government’s attention”...”You could face recoupments, false claims allegations, and civil monetary penalties”
  - Default settings (i.e., documentation by exception) could present red flags to auditors
  - When charts appear ‘cloned’ (i.e., templates & pick lists) “an auditor may ask questions”
  - EMR software, by filling in stored information from separate chart notes, may lead MDs to “select and bill for higher level E/M codes than medically reasonable and necessary”
  - “Don’t let an EMR select codes for you”

# EHRs and E/M Non-Compliance

- January 2007: CCHIT requested comments on their “anti-fraud requirements” for electronic health records
  - Review of proposed CCHIT guidelines and proposals to deal with *fraudulent* EHR features
  - Website is <http://ehrantifrauddev.rti.org/Default.aspx?tabid=36>

# EHRs and E/M Non-Compliance

- Page 6: “documentation process issues – templates, defaults, copy and paste forward, upcoding etc.”
  - “EHRs provide various tools that enable a provider to be more efficient of his/her time when documenting an encounter. These include the use of defaults, templates, copying and other tools....however, they could be subject to fraud and abuse. Having an audit version of the EHR which indicates which of these tools were used could enable detection of patterns of abuse or fraud”
  - Note: the solution to non-compliant (aka ‘fraudulent’) documentation features should not be to document the fraud
    - (and then fine physicians for using the systems that have been certified by CCHIT despite fraudulent design features)
  - The valid solution is to remove all fraudulent documentation features

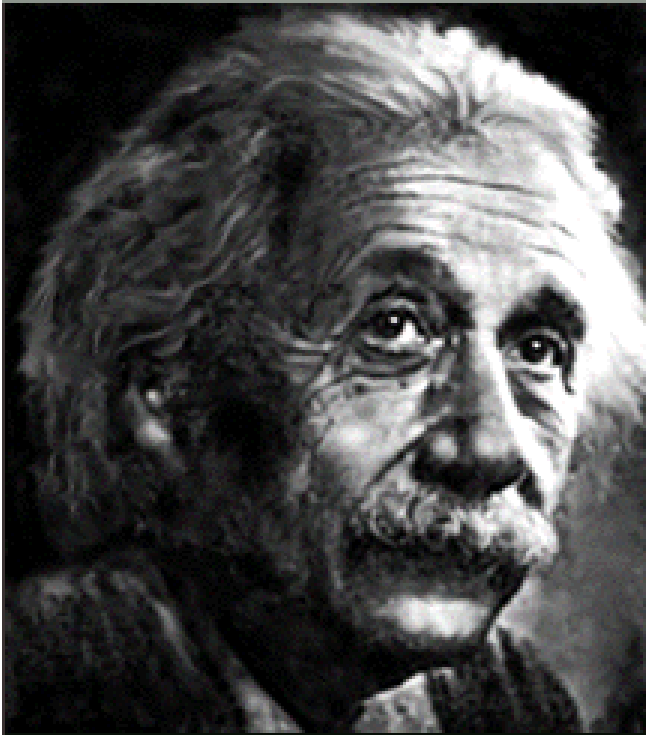


# Where are We Now With H&P in Electronic Records?

---

- We therefore currently have 650,000 physicians x 375 EHR systems for a total of approx 200 million permutations of (*non-standardized, non-compliant*) physicians' H&Ps
- We do NOT have, and never can have, sufficient manpower to address the needs of this status quo!

# What *Core* Medical Record Problem(s) are We Attempting to Solve with Workforce?



Einstein's assessment of the atomic bomb:

“The release of atomic energy has not created a new problem. It has merely made more urgent the necessity of solving an existing one”

- {*substitute “electronic record” for “atomic energy”*}
- {*substitute “E/M compliance & medical record quality” for “existing one”*}

- “A problem stated is well on its way to solution”

- John Dewey, philosopher, 1930

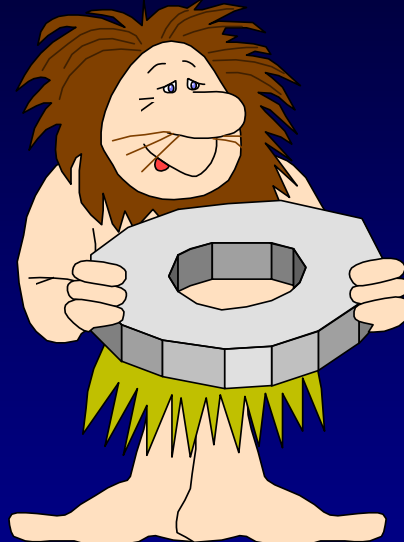
# There Are Two Ways to Solve Our Perceived Need for Manpower for H&P

- Increase the amount of manpower vs.
- Correctly identify the *core* problems and target the manpower we already have (professional coders) to solve these problems
  - Train health information users
  - Train health information specialists (to train users and patients)
  - Both needs will be reduced *dramatically* by developing usable, compliant electronic systems for the H&P

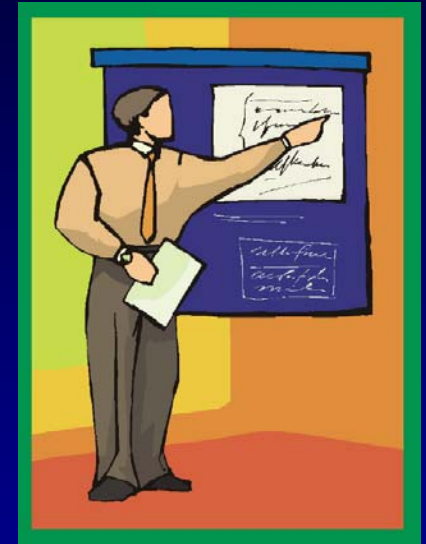
# Adding an EHR to an *Optimal* Paper World



+



+



1) Standardized  
E/M COMPLIANT  
medical record

2) Effective  
Medical Record  
Tools +  
**legibility**

3) Effective  
Medical Record  
Education

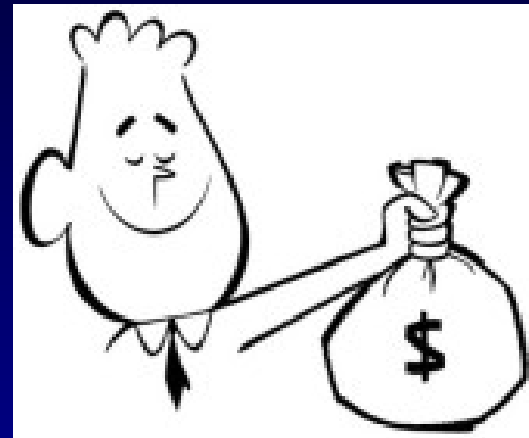
# Adding an EHR to an *Optimal* Paper World

+



4) Actual  
resource based  
payment

+



+

5) Compliant  
Reimbursement  
Practices (incl. CMS)

# Adding an EHR to an *Optimal* Paper World



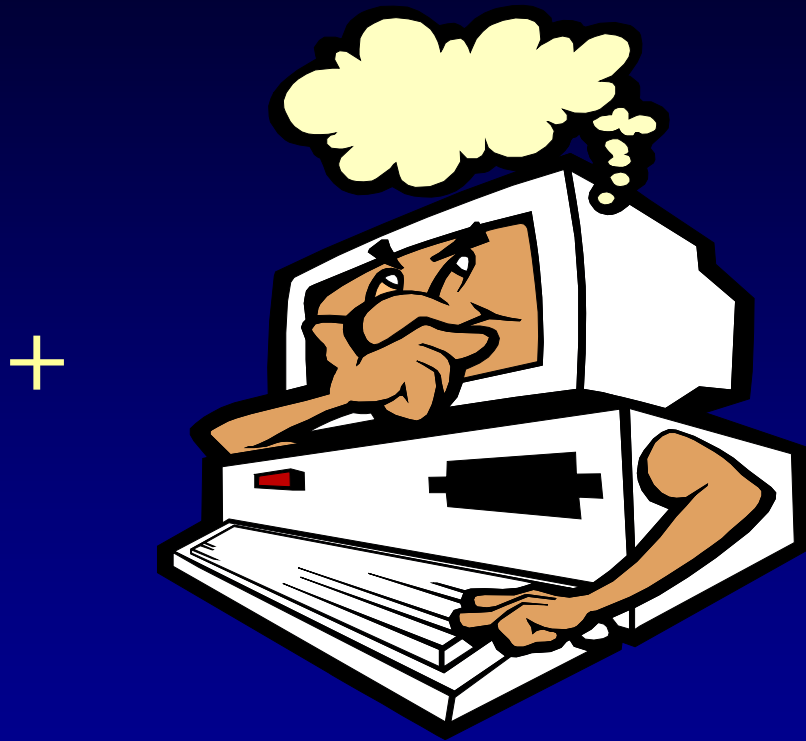
6) Well-run  
medical office

+



7) Well-trained MD with  
efficient, compliant,  
usable paper record

# Adding an EHR to an *Optimal* Paper World



8) Well-designed EHR: (at least as efficient, compliant, usable & productive as a good paper record; and requiring only 8 hours to learn)

=



9) How great are our manpower needs?

# What are the *Real* Problems?

We need to identify, and correct, the E/M issues in physicians' existing records before we ask them to implement a technology that will magnify those issues





# What are the *Real* Problems?

We require an EHR user interface that meets criteria for:

- 1) E/M compliance
- 2) Guiding and reinforcing a quality H&P
- 3) Usability / flexibility
- 4) Efficiency



# Solutions to the *Real* Problems?

(Do these Require More Manpower or Something Else?)

- Lack of a standard E/M medical record (as taught early in medical school)
  - We (incl. CCHIT) must acknowledge and implement the E/M std.
- Med school: lack of E/M training; lack of **legibility**
- Failure to provide effective E/M tools
- Lack of effective education in medical records that can be used in the real world (**CPC manpower is available now**)
- Under-reimbursement for work and practice expense provides inadequate *time* for quality care
- Non-compliant payer practices corrupt physician capabilities

# Solutions to the *Real* Problems?

- Poorly administered offices in paper world  
(QIO & MGMA manpower is available now)
- Current EHR systems do not uniformly fulfill all physicians' H&P requirements of:
  - Being E/M compliant (including *medical necessity*)
  - Promoting *individualized* documentation
  - Providing for efficient data entry of *quality* patient H&P  
(time ↑ 70% vs. paper if physician is the DEO)
  - Promoting quality *diagnostic* medical process
  - Being *intuitive* and easily learned (< 8 hours)
  - (addressing these EHR needs will significantly address physician training manpower needs)

# Identifying Source of Data Entry Problems

- 1) The physician is assigned as the data entry operator ('DEO')
- 2) Requirement for synchronous entry of all data

These 2 fundamentals  $\Rightarrow$  loss of narrative interface (free text) and  $\Rightarrow$  necessity of employing pre-loaded and restricted vocabulary that is inadequate for input of *individualized* patient-specific clinical information

# Practice Transformation Pyramid

# HITr = Manpower Needs for the H&P



## HIE: connecting communities

## HIE: Introduce "Connectivity" for Clinical Laboratory, X-ray, and Pharmacy; P4P data transmission

**Medical Record Implementation:** may include mail-merge consultation letters, operational "clinical decision support," and a managed patient profile section. Effective backup systems

## PREPARATION for practice work flow transformation

## PREPARATION of physicians' for medical records

## PREPARATION of the EHR's data input capabilities

**PREPARATION**  
for the  
physician/EHR/patient  
dynamic, at point of care

## Making a decision to adopt HIT; ASP model vs. hardware

## FOUNDATION

(final decision may be deferred until pyramid level 1)

## Performance & satisfaction guarantees in contract

Organization must be purchasing an evolving process, NOT a static technology



We already have the Manpower  
to Transform a Quality H&P System !

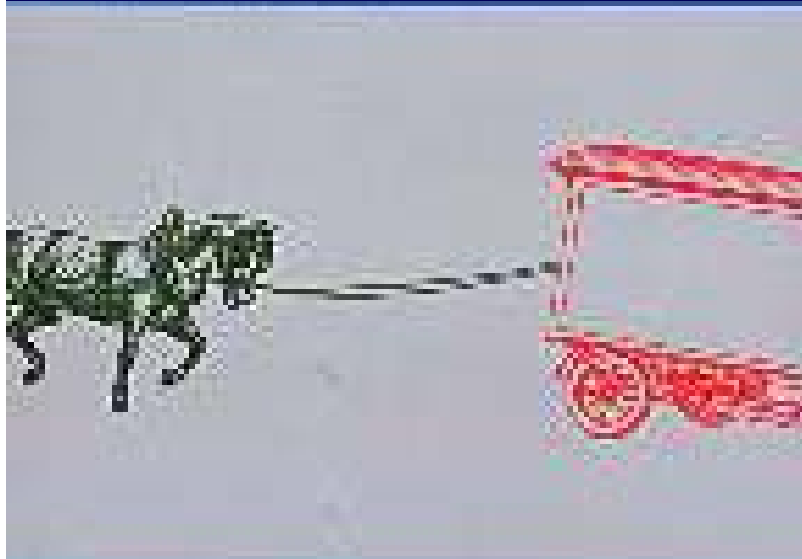
What we lack is a Quality H&P System !

# We Need to Put E/M in the EHR Spotlight

- Obtaining & documenting a high quality H&P
  - Emphasized early in med school
  - Then corrupted by absence of tools to apply it in the time physicians have for care
- We must standardize & institutionalize the tools needed to implement efficiently this high quality compliant record, beginning during medical school



# We also Need to Put the Horse Before the Cart



- Manpower needs are critical to train physicians in the H&P component of EHRs
- This need gives us another reason to look at the physicians' H&P and solve the data entry challenges
- We must have trained physicians and compliant tools *before* determining our manpower needs



# Questions?

*thank you for your interest*



Stephen R. Levinson, M.D.

ASALLC@aol.com

[www.PracticalEM.com](http://www.PracticalEM.com)