Assaying the Next Product Generation: Evolution for Enhanced Quality, Efficiency, and Productivity

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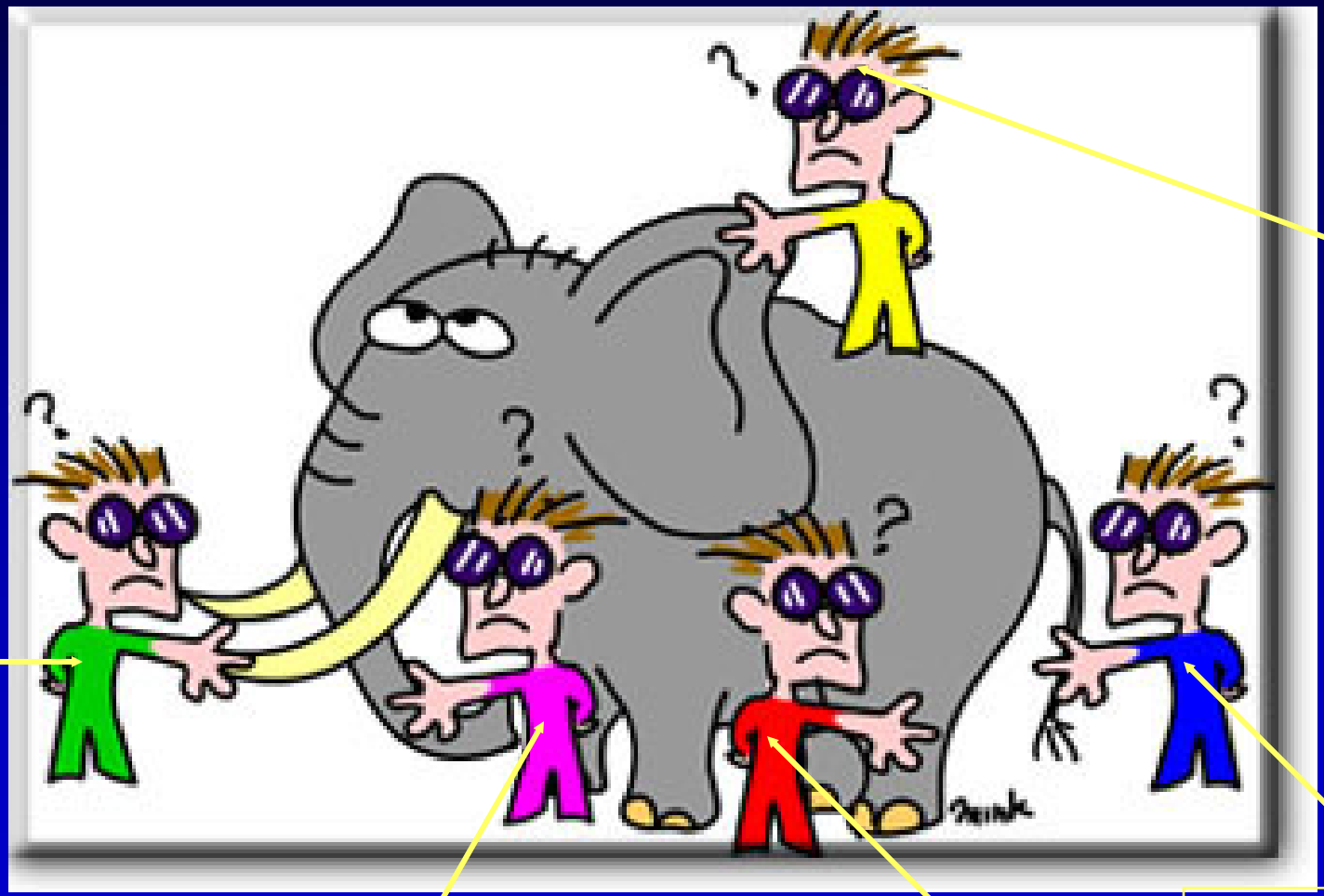
EHR (Elephantine Health Records) Means Different Things to Different Stakeholders



M.D.s

CPOE

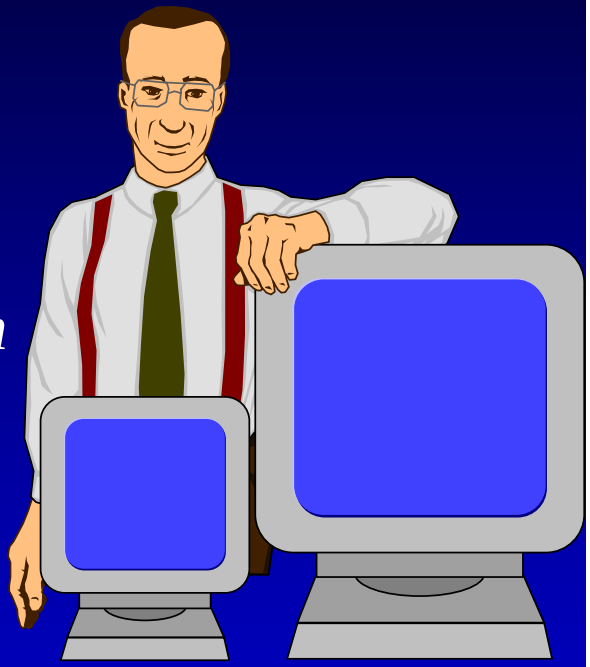
Hospitals

Payors

Communities

To Physicians, "EHR" Means the Medical History and Physical (H&P)

- "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)
- Addressing this priority involves assessment of the data entry features of the Physicians' H&P
  - An area that has generally lacked scrutiny in setting our quality standards and in guiding EHR selection



HIT Truisms

- "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)

General Medical Record Truisms

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

CPT's E/M System is a Codification of the Quality Care Approach We Teach Physicians

- The text "Bates Guide to the Physical Exam and Medical History" matches concept for concept, and almost word for word, with CPT's E/M Section & Doc. Guidelines
- Therefore E/M is not only a coding system, it can be used as a common framework to facilitate quality patient care
- This framework is the logical (and only sanctioned) basis for the evolution of a CUI

General Medical Record Truisms

- The Reality:
  - Student physicians are provided only pen & paper
  - With such limited technology, a quality H&P requires 45-60 minutes to perform & document
    - Impossible scenario in current economic environment
    - Leads to severe compromise of the ideal H&P: SOAP
  - We now have tools in the paper storage format to promote comprehensive H&P, when medically indicated, in 10-15 minutes (with full compliance)

Bringing Success to the Electronic H&P

- Analysis of current status of EHR Physicians H&P
  - Success in data storage & retrieval
  - Challenges in data entry design & functionality
- "I do think there is some **groundbreaking work** needed at the fundamental level for clinical information, including work that needs to be done to make this (*i.e., 'medical H&P data input'*) easy and useful"
  - Dr. Carolyn Clancy, director of AHRQ
    (at eHI's Connecting Communities Learning Forum, April 2006)

Bringing Success to the Electronic H&P

- I hosted a session at MS-HUG “where there was some lively debate on the need for more intuitive, less costly solutions for clinical documentation”…..
- “a session at MS-HUG on ‘A Common UI for the Electronic Medical Record: Lessons from the NHS’…..reviewed work Microsoft is doing to develop a more common user interface for clinical systems in the United Kingdom”
  - Dr. Bill Crounse, Microsoft Healthcare Industry Director, on his healthblog site, 9/5/2006

Bringing Success to the Electronic H&P

- Analysis of current design features that challenge the data entry characteristics of the Physicians' H&P:
  - The physician is assigned as the data entry operator ('DEO')
  - Requirement for synchronous entry of all data
- This foundation ⇨ loss of narrative interface, and ⇨ necessity of pre-loaded and restricted clinical information

Physician Criteria for the H&P, in *ANY* Format

- 1) Compliance
- 2) Efficiency
- 3) Usability
- 4) Quality Care
- 5) (Productivity)
- Addressing #1, 2 & 3 ⇨ #4 & 5 (care and reimbursement levels appropriate for severity of each patient's illnesses)

Compliance Requirements

- E/M compliance is a codification of the comprehensive H&P taught to student physicians as the ideal for quality and cost effectiveness
- Data Entry for the Physicians' H&P must ensure 100% E/M compliance, including consideration of ***Medical Necessity***

Compliance Challenges

- Current H&P compliance crisis:
  - Current software challenges in all components of E/M documentation and coding
  - Current software lacks *documentation* of complete medical decision making
  - Current software lacks *documentation* of medical necessity
    - Medicare Carrier Manual states “medical necessity is the overarching criterion for payment”

Compliance Challenges

- Part B News article on Medicare Audits of EHRs, 5/06
  - 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"

Compliance Challenges

- Dr. Bruce Rappaport's analysis of compliance issues (consultant for Rachlin, Cohen & Holtz, LLP; medical director of Best Choice Plus; AAPC annual meeting, 4/06)
  - Pattern documentation lacks quality & compliance
    - "Do not purchase an EHR that lacks ability for free text data entry"
  - Non-compliance of all automated entry of clinical information
  - Coding based on bullet points, not medical necessity
    - "Turn off the coding function of EHRs because no NPP"
  - Complacency (by physicians)

Efficiency Requirements

- While promoting medical quality and E/M compliance, in 15 minutes MD ***must*** be able to:
  - Perform and complete documentation of a medically indicated, audit-proof, level 4 or level 5 initial patient visit
  - With individualized narrative information in all appropriate areas of the medical record
  - Including completion of counseling the patient, ordering tests, ordering treatment, & charge entry

Efficiency Challenges

- Systems need to provide appropriate interface for each section of the medical record
  - "Graphic" interface
  - "Narrative" (free text) interface
    - Elimination of pick lists & pre-loaded templates for these sections

Efficiency Challenges

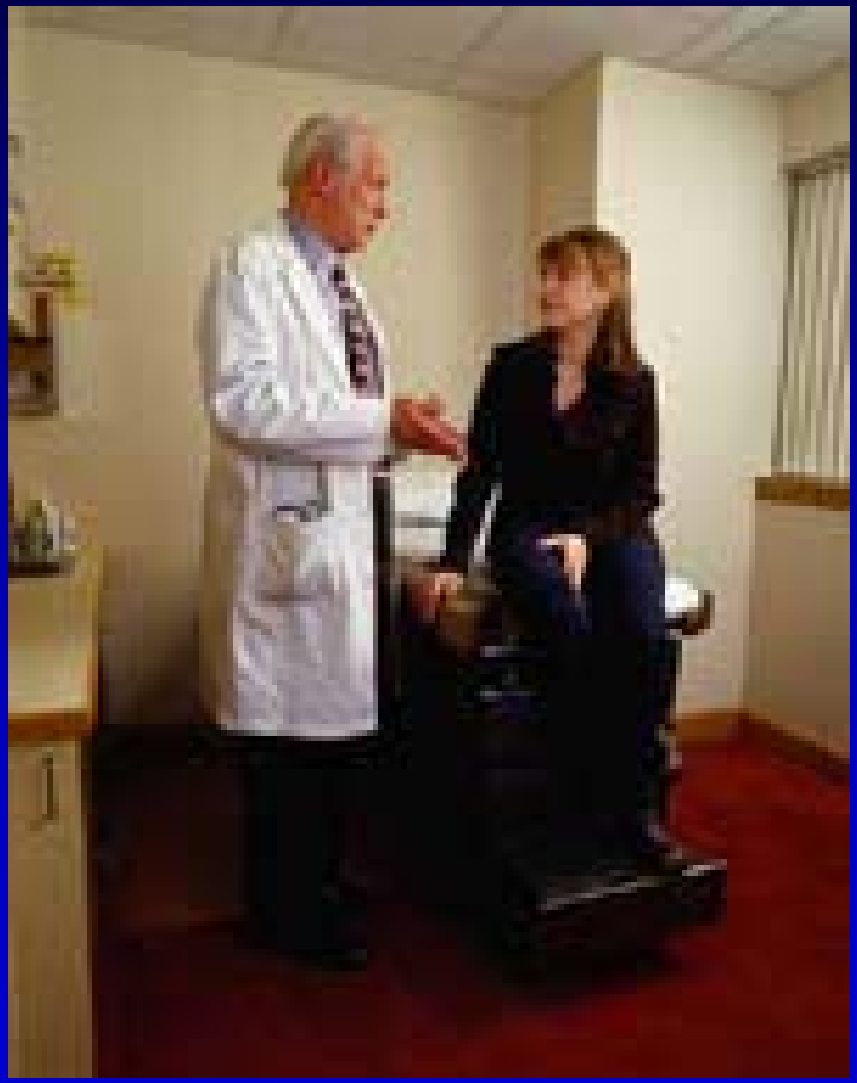
- Systems should permit appropriate data entry by staff and by patients

- *Current approaches require at least 70% more time than a paper record to enter identical high quality, compliant, individualized medical information

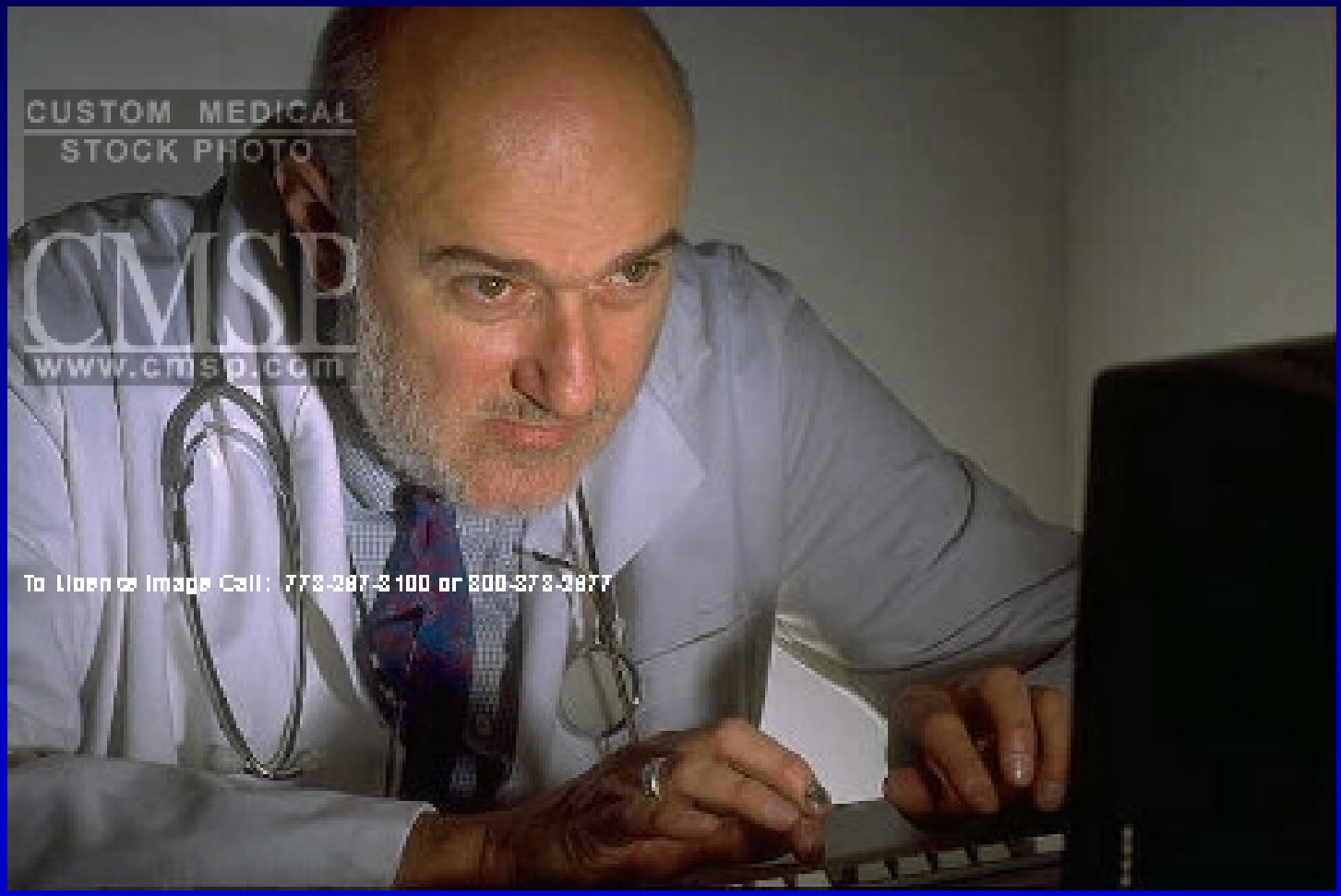
Usability Requirements

- Flexibility to allow hybrid data entry modes that suit individual physician preferences and talents
  - Dictation for transcription or voice recognition
  - Writing on tablet PC
  - Writing on paper with DEO entry
  - As well as typing
- Ability to permit direct eye contact with patient during an entire encounter

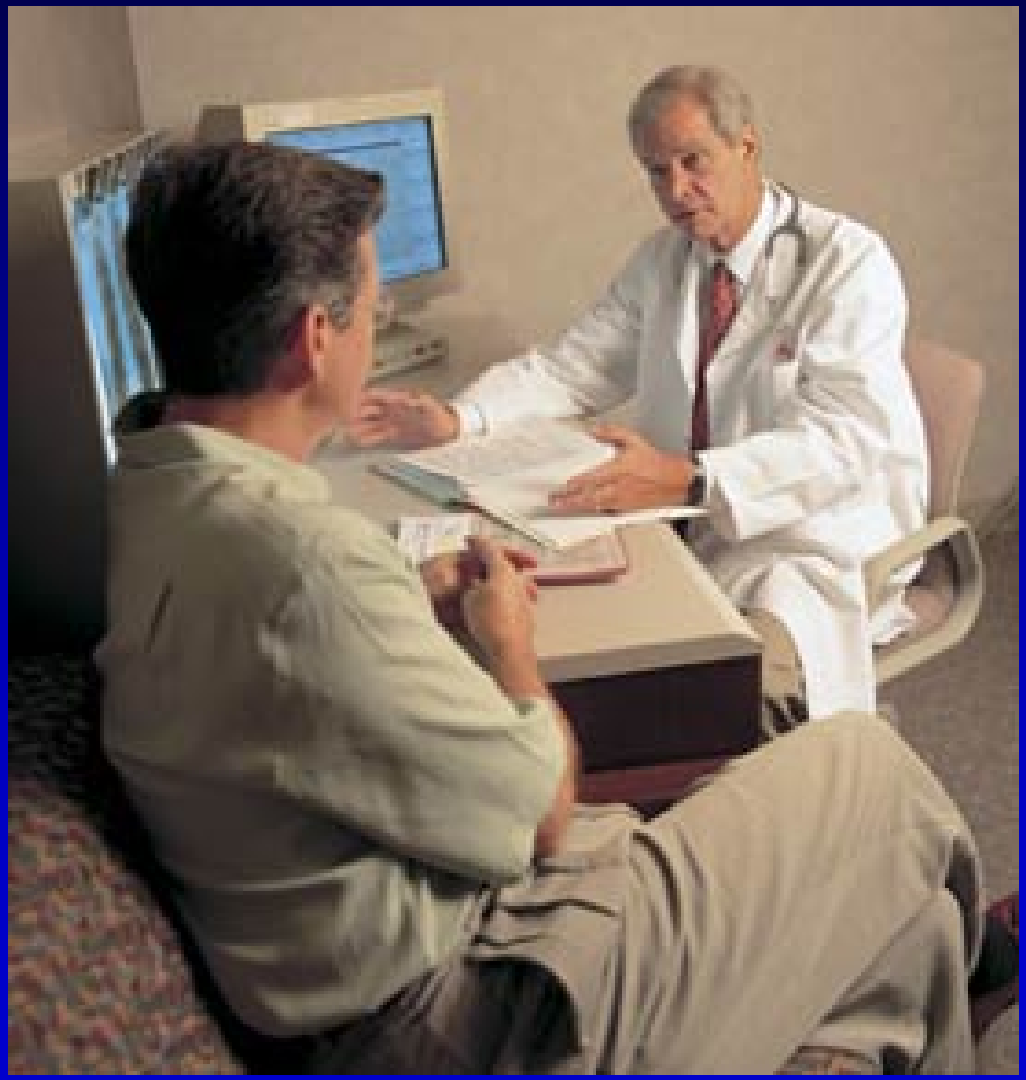
Patients Want & Expect to See This (and so should physicians)



Patients Do NOT Want This (and neither should physicians)



However, Everyone Can Be Happy with a Hybrid System!



Quality Requirements

- Narrative descriptions that include
  - History of present illness: “tells the patient’s story”
  - Abnormal ROS responses: provides individualized background and contributes to understanding each patient’s level of medical necessity
  - Abnormal examination findings: “paints a verbal picture of the findings”
  - Medical Decision Making: “creates a logic tree” for diagnosis and “provides a blueprint” for future care

The H&P Should be a Reflection of the Care Provided

- With conventional approaches, regardless of the format, all too often it documents the limitations!

Similarly, Medical Care is a Reflection of the Medical Record Tools Employed

- Enhancing the quality of the tools enhances the quality of the care
  - Improved diagnosis
  - Improved planning
  - Audit protection
  - Medico-legal protection

Productivity Enhancements

- ROI has been problematic for current EHRs
- Most real income benefits of HIT would derive from effective “health information transformation”
  - Transforming workflow ⇨ savings on storage & retrieval costs of paper systems
  - Providing MDs with transitional training in an effective *conventional* system ensures training in compliance & increases productivity
  - H&P enhancements for EHRs should eliminate the drop in productivity on implementation
  - Iterative training program should reduce or eliminate rate of failed implementation

Success for the Electronic H&P

- Proposal: we need to bring the same innovation, enthusiasm, expertise, and commitment to H&P data entry design that developers are bringing to EHR data storage design, clinical decision support, interconnectivity, interoperability, and HIE

Success for the Electronic H&P

- To move to the next generation of the physicians' H&P, we need to update the 2 fundamental data entry assumptions:
- The physician should not be required to be DEO
- While clinical documentation needs to be synchronous; most data entry does not need to be synchronous
  - "In the flattened world, communication is asynchronous"
    - Tom Friedman, author of "The World is Flat"
- Such changes should facilitate compliance, efficiency, and usability, thereby promoting quality care and appropriate levels of productivity for physicians

Thank you for
your interest,
your questions,
and your suggestions

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