EHRs: Pitfalls and Best Practices

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Family Medicine Associates LLC

- Single specialty practice
- Three sites
- Physician led teams
- 11 family physicians
- 25 NP/PAs
- 2002: Penchart
- 2010: e-MDs
EHR: circa 2000

EHR: 2014
Top 17 things our EHR does:

1. Note creation:
   • New data at time of visit: HPI; PE; Review of Systems
   • Data that may be pre-entered and brought forward, but should be updated: PMH, medications, allergies, SH, FH, HC proxy

2. Medication list; e-prescribing; drug interactions; disease specific alerts
3. Labs; flow sheets; sharing results with patients.
4. Documents: consultant notes, hospital records, etc.
5. Messaging: phone messages; intra-office messages. May be attached to a chart or unattached. IM.
Top 17 things our EHR does:

7. Tracking: were the tests done?
8. Referral management: sending and receiving patient information; referral tracking.

Top 17 things our EHR does:

10. Documentation for Meaningful use; Patient Centered Medical Home.
11. Management of quality incentives: AQC, PQRS, etc.
Top 17 things our EHR does:

12. Patient portal. Export information to patients electronically (or by letter?)

15. Confirmation of insurance coverage.
16. Coding and billing.
17. Patient flow in the office: check-in, transfer to MA, provider, check-out.
This is too much for any EHR to do well, by itself!

- Our EHR has become a platform that integrates several programs
- Variable degrees of integration
- In most cases we have several options to choose from when picking a service

<table>
<thead>
<tr>
<th>Type of Service</th>
<th>Total No.</th>
<th>No. per Visit</th>
<th>No. per Physician per Day</th>
<th>No. per Patient per Yr</th>
</tr>
</thead>
<tbody>
<tr>
<td>Visit</td>
<td>16,640</td>
<td>NA</td>
<td>18.1</td>
<td>2.0</td>
</tr>
<tr>
<td>Telephone call</td>
<td>21,796</td>
<td>1.31</td>
<td>23.7</td>
<td>2.6</td>
</tr>
<tr>
<td>Prescription refill</td>
<td>11,145</td>
<td>0.67</td>
<td>12.1</td>
<td>1.3</td>
</tr>
<tr>
<td>E-mail message</td>
<td>15,499</td>
<td>0.93</td>
<td>16.8</td>
<td>1.8</td>
</tr>
<tr>
<td>Laboratory report</td>
<td>17,974</td>
<td>1.08</td>
<td>19.5</td>
<td>2.1</td>
</tr>
<tr>
<td>Imaging report</td>
<td>10,229</td>
<td>0.61</td>
<td>11.1</td>
<td>1.2</td>
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<tr>
<td>Consultation report</td>
<td>12,822</td>
<td>0.77</td>
<td>13.9</td>
<td>1.5</td>
</tr>
</tbody>
</table>

* Patients were included in the active caseload if they had any interaction with the practice in the listed categories of activities during calendar year 2008. NA denotes not applicable.

† The values are based on the work of four full-time-equivalent physicians who each worked 50 to 60 hours per week for 230 workdays per year.
Our current line-up

- In addition to e-MDs, we use:
  - Surescripts: prescription management
  - Labdaq: lab testing/results
  - Data-file: documents
  - Softros: messaging
  - Phytel: population management
  - HealthLens: templates
  - UpToDate: on-line reference
  - Gateway: billing assistance

Prescription management

- Program integrated with e-MDs
- Refill requests sent to individual prescriber; connected to medication list
- New Rx can be e-prescribed, faxed, or printed
- Program keeps track of refill dates, amounts
- Our program does not permit e-prescribing for scheduled meds.
Lab information service

- Orders transmitted from EHR to LIS (?)
- LIS tracks specimen: at primary and reference labs
- LIS retains results; places results in EHR
- LIS interfaces with lab instruments
- LIS interfaces with reference labs
- Fee for program; ongoing service contract

Document management

- Surprisingly annoying.
- Challenges: To accept documents arriving by fax, e-mail or snail-mail;
- To identify the ones that need to be signed and sent back (e.g., VNA, Hospice, or DME forms) for hard-copy distribution;
- Import all into the appropriate chart with date, label;
- Allow physician review and sign-off.
e-filing Process

- Anything that is faxed to our office is sent electronically to a bulk file in our EHR
- DataFile Technologies representative monitors bulk file throughout the day and imports documents into patients charts with title and date of service and will send to providers if needed
- More expensive for e-mailed documents

Population management

- We pick target conditions or tests
- We pick visit or testing intervals
- They comb EHR for last visit or test date
- If patient is due for next visit or test- they contact them. Patients are allowed to opt out.
- Contact can be by phone, e-mail, or text
Billing/coding aids

- “Scrubbing” claims: compare claims to insurer-specific rules
- Bounce back claims that are likely to be rejected, for editing
- Keep track of insurer’s fee schedules; compare amounts paid to the schedule
PCMH Standards

1. Enhanced access and continuity
2. Identify, manage patient populations
3. Plan and manage care
4. Self-care support; community resource
5. Track and coordinate care
6. Measure and improve performance

PCMH

- The challenge: improve patient care; and prove that you are doing so.
- MU accounts for about 17% (one sixth) to the PCMH requirements.
- Can providers document without adding time to the visit?
- Restructuring the templates: no easy task
PCMH - Important Condition #1 Diabetes

Diabetes
Select
• *FMA PLAN: Diabetes

...continued

Diabetes
Document
Self Management Goal
→ Specifics and then
→ Barrier / Strategy
Diabetes Document
Self Management Plan
 Reviewed
 Ability
 · Hi / Med / Low

Understanding of Medication
What’s next?

- Prediction: trend towards EHR as a platform integrating a variety of programs—will continue. My wish list:
  - A patient portal that works;
  - Clinical decision support from a trusted source;
  - Useful drug/drug and drug/disease interaction programs.