

Supporting Practices in EHR Adoption: A Physician's Perspective

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Charts are for documentation, right?

- In a paper world, charts function as
 - Archival records perhaps reviewed later
 - Evidence to support billing
 - Key evidence in malpractice suits
 - Repository of “all the information” on a patient
- Connection between charting and payment
 - Longer the note, higher the fee
 - “Work we have to do, but don’t get paid to do”
 - Literally – and derisively – “paperwork”

What do doctors do with EHRs?

- Use the word-processing features
 - 51% of financial return on EHR comes from more aggressive coding
 - Current products major “attraction”: create long, detailed notes effortlessly
 - “Higher value” notes (???)
- **4%** of adoptions are “comprehensive”
- This is clearly not what you want, and not likely to be “*meaningful use*”

My “framework” for supports docs will need

- Technological support
 - Keep a system *working*
- Training support
 - Learn how to *use the system* as designed
- Work flow re-design support
 - Change the way work is done with the system
- Most important: change in (self) expectations
 - Change in job description, change in payment

Technological support

- The printer in room 3
 - If it doesn't work, docs won't print scripts
- **NO DOWNTIME**
 - Patient needs are ongoing, no room for crashes
- Network management, hardware issues, software bugs, virus protection, etc.
 - Small businesses will need strategies to cope with all this, and it's not what vendors sell

Training support

- Must reach *everyone* in office
 - Some will need training on using a mouse
 - **Most** – especially doctors – will need typing
- How to use the system and its features
- “Super users”
 - In-office folks to troubleshoot problems

Work flow re-design

- “Go live”- but everything’s *still* on paper
 - Day 30- *almost* everything’s still on paper
- Everyone’s job changes
 - Prescription refill, filing, appointments, labs
- Evolutionary process
 - Initial work flow: focus on data conversion
 - Later work flows: start to use “new capacities”
 - Structured vs. unstructured data
 - *Ongoing* new delegations- even 5 years out!

Change in (self) expectations

- “Value” thought to equal “payment”
 - Huge lack of fit in primary care
- Shift to non-visit based care
- Using EHR functionality for population mgmt
- “New” cognitive models (e.g., Wagner, IHI, IPIP)
- If you don’t change payment, you contribute to the inertia maintaining the old system

How we are “happier doctors” with an EHR

- Meet patients’ needs more effectively
 - Data in a context (“what was my weight last time?”)
 - “Can you fax that prescription?”
- Activate a team
 - Can delegate activities safely and reliably
 - Staff can take initiative
- Can do proactive, non-visit based care
- E-mail, interactive web have been great

Some “structural” issues for states

- Who will be your “HIT extension” provider?
 - Can guarantee you will need one!
 - Can you create “learning communities”?
- How to flow funds for HIT?
 - Good to have it “pulled out” from regular flow
 - Use as opportunity to get away from FFS
- Linkage with other HIT needs/initiatives?
 - Public health? E-Rx? QI/performance reporting?
- Role of managed care intermediaries?

Some technology/training resources you can use

- QIOs- got ready with “8th scope of work”
 - DOQIT-U:
<http://www.masspro.org/HIT/DOQU/index.php>
- AHRQ has a big investment here:
 - <http://www.norc.org/projects/ahrq+national+resource+center+for+health+information+technology.htm>

Work flow, job re-design resources

- Institute for Healthcare Improvement (IHI.org)
- IPIP (ABMS: Improving Performance in Practice)
 - <http://www.ncafp.com/home/programs/ipip>
- ABMS Maintenance of Certification (MOC) programs
- Patient Centered Primary Care Collaborative
 - <http://www.pcpcc.net/> (employer coalition)