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One-Size EMR Doesn't Fit All

Specialties had better keep their unique workflows in mind when selecting and electronic medical record.

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Nationwide, about 24 percent of doctors are using some kind of electronic medical records system (EMRs) and about 11 percent are using a fully integrated system. These systems are revolutionizing the way the healthcare industry works. But many specialty practices don't realize the differences between systems and companies and may invest in a generic program rather than a specialty-based solution.

The paperless illusion

A patient wouldn't consult an orthopedic doctor for a digestive problem; the patient would make an appointment with a gastroenterologist. This same principle applies to EMRs. On the surface, EMRs seem to operate equally across specialties, but closer examination reveals many fall short. One-size-fits-all systems create a cumbersome implementation process for physicians — often performing poorly even compared to paper files. Users then resist the changes and the EMR becomes a roadblock to a more efficient and profitable practice. An effectively designed specialty-based EMR bridges this gap by shortening transition time and providing an optimal platform for medical personnel.

Every practice, regardless of specialty, wants to decrease costs, become more efficient and provide better patient care. Typically, in a gastroenterology practice, procedures requiring preparation are performed in hospitals or ambulatory surgical centers and are often inconclusive without anatomic pathology results that arrive at a later date. These results may change the patient's diagnostic profile and treatment plan. Understanding workflow differences between medical specialties is critical for successful EMR implementation.

Most EMRs are designed for primary care with one-size-fits-all systems — procedures are rare, diseases varied and outbound referrals common. Much of the patient's information (and in certain specialties about half the practice revenue) is related to procedures and chronic disease management, yet little or no attention is given to these activities. The paperless illusion is created using scanning, faxing and generic text processors that provide little benefit or medical insight without human interpretation.

The complexity of procedures

Surprisingly, even the most advanced EMR vendors offer procedure templates that seem attractive on the surface yet fall short during implementation because procedures:

- may require embedded images
- alter diagnostic and treatment plans
- generate ancillary documentation (like discharge notes and referral letters)
- originate special laboratory testing
- are subject to complex coding and billing rules that have a high impact on revenue

The complex nature of medical procedures has given way to stand-alone documentation systems that exchange limited information with EMRs and specialized laboratories. These systems usually send a readable document back to the EMR. This image document has insufficient information to change treatment plans, laboratory orders, diagnoses or follow-up activities in the EMR chart. The interlinked EMR-Procedure systems from different vendors result in a complex and semi-functional solution requiring many moving parts, preventing specialists from delivering better care at lower cost.

The risks of poor integration

Physicians who perform diagnostic procedures for high-risk patients in surgical centers need to react aggressively to test results. This response necessitates a well orchestrated interaction between the practice, laboratory, primary care provider, insurance and patient. In this complicated process there is a chance many things can go wrong such as:

- Surgical center misses critical patient information collected at the practice
- Practice does not receive the laboratory result
- Practice misplaces the chart and the patient is not contacted
- Patient does not respond to multiple communications
- Primary care physician is not notified of the result
- Insurance company does not authorize treatment for lack of adequate documentation.

These and many other oversights that could lead to patient risks can be avoided by having integrated systems that seamlessly reuse information across all specialty locations and interconnect with all players, including the patient.

Benchmarking and P4P

Physicians are subject to quality and performance gauging initiatives that impact revenue and patient outcomes. Medicare is promoting the Physician Quality Reporting Initiative (PQRI), while certain specialties promote benchmarking. These initiatives require extensive information from all points-of-care contact, including evaluation and management, diagnostic and therapeutic procedures, patient interactions and laboratory result management.

Unfortunately generic EMRs have proven insufficient to meet benchmarking and PQRI measures. For example, gastroenterology PQRI requires information that links medical diagnoses (GERD) with endoscopic procedures (EGD) and ensuing laboratory results. Assembling this information requires highly specialized systems that are able to integrate all episodes of care and interactions, not just medical office visits.

Certain specialties require non-generic EMRs to offer the best possible care and return on investment. Truly specialized EMRs should meet industry requirements (CCHIT), offer relevant diagnostic and therapeutic procedure modules, establish links with relevant specialty partners and incorporate specialty-specific knowledge sufficient to meet present and future specialty needs.

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