THE PAYOFFS OF GOING PAPERLESS

Here's how one optometrist handled the switch to electronic health records, and why this transition is more important than ever.

My first position out of school was with a practice that still utilized paper charts. In a way, I was relieved. Each of my externships had EHR systems, all different from one another, and by the time I learned one system, I was starting over somewhere new. Paper exams seemed so simple.

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THE PROBLEM WITH PAPER

It only took a few months on the job to begin to see the pitfalls of the old-fashioned written exam. First of all, embarrassingly enough, I had trouble reading my own terrible handwriting. Looking back at previous exams, I couldn't always decipher what I wrote and sometimes I couldn't remember what had been done. Reading the handwriting of the other doctors was even more difficult. It was a guessing game until I learned which diagnoses and abbreviations each doctor's scribble stood for. Unfortunately, this is a common problem with written exams and prescriptions. According to the Institute of Medicine of the National Academies of Sciences, Engineering, and Medicine, preventable medication mistakes injure 1.5 million Americans a year, with most of these cases due to unclear dosing instructions and illegible writing.

The problems didn't stop there. Misplaced charts, missing exams and test results, and out-of-order paperwork meant I spent more time charting and searching for information than actually seeing patients. Looking for past information meant flipping through contact lens follow-ups and eyeglasses orders for the relevant medical data. I remember several occasions where we couldn't locate a patient's chart. Had someone filed it incorrectly? Was the chart taken to another office location? It was very frustrating and unprofessional when we had to explain to the patient that we couldn't find their records.

THE SHIFT

Within six months, that office had an EHR system up and going. Change was slow at first. New patients were easy since I could start their records fresh. For existing patients, I referenced their paper chart in conjunction with the new computer one. Our staff also had to take the time to scan in the old information so we had a record of it in the new system. The headaches of adopting an EHR system continued for about a year until the majority of patients had their paper records transferred into the new system.

We were a smaller, newer office with a healthy patient population. I can't imagine the stress and staff hours it would take to switch all of the information over to electronic health records if we had a whole room full of stuffed paper charts to tackle. So why deal with the hassle and expense if you have an established practice with thousands of charts that need transferring?

CODING

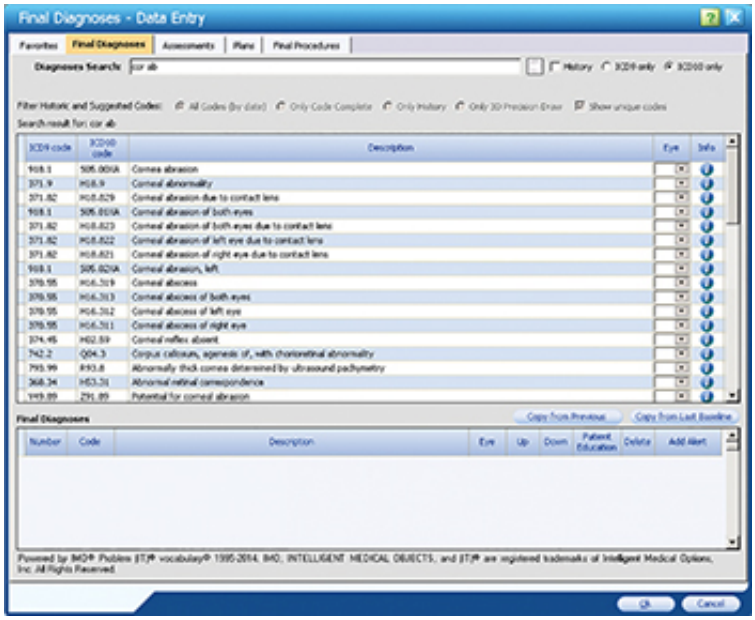
Let's start with the obvious: Conversion to ICD-10, and subsequently its billing, will be incredibly time intensive to do properly without electronic health records.

Take, for example, coding a right eye corneal abrasion. The old style ICD-9 code was 918.1, which can easily be listed on a paper super bill. The new ICD-10 code would be as follows:

S05.01XA
S05 for injury of conjunctiva and cornea without foreign body
01 for right eye
XA for initial encounter

ICD-10 codes require more in-depth coding, including laterality. In the case of an ocular injury, the first encounter and subsequent encounters are coded slightly differently. In addition to a longer code, you will need to code the reason for the injury (fingernail scratch, tree branch, etc.). ICD-10 coding gives a more detailed story of the findings but it also expands the number of codes used exponentially.

No longer will it be possible to have a list of common codes that you can select from on a super bill. Without software that selects the correct code, it's easy to see how this process can get overwhelming. A typical optometrist may spend an extra three to five minutes per patient searching for the correct ICD-10 codes. That can add almost an hour to a full day's schedule just to get the coding correct and therefore get paid by insurance companies.



The intuitive ICD Selection Tool on MaximEyes EHR allows you to think in ICD-9 but code in ICD-10.

THE TRANSITION

If you decide to implement EHR, the following are a few ideas that I found made the transition to electronic records smoother:

Choice of software

There are numerous EHR systems on the market and more are being developed every year. It's well worth the time to get acquainted with a system before making a purchase. EHR software is a big expense and it's an added headache to switch between products. If you don't like the layout of the system, it will be much more difficult to implement it. Ideally, an EHR system that fits intuitively with your current charting system will make the change easier. Choose something that fits with your style of practice and record keeping. Notable ones include: Eyecare Advantage (Compulink Business Systems, Inc.), Eyecom3, Eyefinity, ManagementPLUS, MaximEyes (First Insight), Practice Director EHR (The Williams Group), and RevolutionEHR, to name just a few!

Staff training

After selecting the software, make sure the company sets up adequate time to train your staff and is available for troubleshooting for any problems that will arise. You may wish to take a day or two off your normal patient schedule so you have plenty of time and energy to devote to training.

Slower schedule

It may be helpful to run a slower than normal schedule for a few days or weeks. This will give you time to fix any problems that arise without the added stress of running behind schedule.

Scribes

If your practice has the talent and personnel, a scribe can be helpful for doctors who are more resistant

to learning new technology. This will allow for practitioners to interact more with the patient, rather than typing and staring at a screen.

Going paperless can seem daunting but the payoff in terms of efficiency, accuracy, and cost is worth it. By press time, the U.S. will have switched to the ICD-10 system and ICD-11 is on the horizon. Add in meaningful use requirements for Medicare, and it will continue to get more difficult to utilize old-fashioned paper charting and still get paid by managed care.

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