Your EMR: Why achieve meaningful use level 3?

In British Columbia, 91% of eligible full-service family practice and specialist physicians (more than 5000 in total) are using an electronic medical record (EMR) in their practice.

With one of the highest rates of EMR adoption in Canada,[1] BC joins progressive health care systems around the world that are advancing the meaningful use of EMRs to improve the efficiency, safety, and quality of patient care, and ultimately patient health. And for good reason.

Meaningful use (MU), which can be described as the intelligent use of quality information, is critical to the evolution of health care. It is a crucial tool to help providers effectively manage increasing numbers of aging patients who present with complex health issues and chronic disease, and to involve patients in their own health.

An EMR that is maximized to its full potential, starting with meaningful use level 3 (MU3), is foundational to an optimized medical practice. With the application of consistent, robust data, the technology becomes a pivotal tool for physicians to assess and improve the quality of care they and their practice team are providing to their patients.

Advancing toward meaningful use

EMR adoption, with basic functionality like automated billings, scheduling, and text notes, is just a starting point. Physicians can increase meaningful use over time, with each level providing greater functionality and ability to improve practice efficiencies and clinical effectiveness.

This article is the opinion of the GPSC and has not been peer reviewed by the BCMJ *Editorial Board.*

Currently in BC, more than 2600 family physicians are receiving support from the Practice Support Program–Technology Group's Post-Implementation Support program, to move through EMR adoption toward achieving MU3. In the fall, a program was also announced for the more than 1800 specialists who are on EMR.

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MU3 is considered a foundational level of EMR use for clinical effectiveness, at which point the consistency and quality of patient data allows for its use in clinical decision making. At MU3, the practice consistently enters fully structured data (that is, problem lists, allergies, prescriptions, etc.) using generally accepted coding standards, and uses the EMR as the principal method of record keeping.

While achieving MU3 can be a challenge, it marks a significant turning point for a practice. At this stage, the combination of good data and advanced EMR functionality can then combine to provide an insightful, reflective view of the practice to better inform decision making. Information from carefully documented records makes practice bottlenecks visible and helps to flag factors that contribute to health outcomes.

Entered just once, data can be applied in many ways to assist physicians with proactive chronic care, quality improvement work, and communication between providers—aspects associated with meaningful use levels 4 and 5 (MU4 and MU5).

- With comprehensive patient profiles, MOAs can identify and track patients with various chronic conditions and issue an appointment reminder. They can also track the kind of time, tools, and follow-up needed.
- Using data, along with EMR-enabled templates, physicians can monitor the progress of patients living with a chronic condition such as persistent pain over time, and determine if there is an increase or decrease in function or quality of life.
- With consistent coding of medications, physicians can review medication profiles and optimize medication management, particularly for multiple medications.
- With accurate problem lists, the EMR can make it easier to link relevant online resources with a patient who has specific diagnosis. Physicians can also then use the EMR to assess their patient panel, look for quality improvement opportunities, and ensure that they are managing their practice and billing effectively.
- By graphing data visually over time, patients can see how they are doing, which can tip them toward greater engagement in their self-management.
- With an up-to-date medical summary, a GP can easily send a clear and complete summary to a specialist with the referral, giving the specialist a more complete picture of the patient's health and other factors.

MU4 focuses on using data for quality improvement, enabling physicians and MOAs to assess their patient panel, focus on specific patient registries, proactively follow up with patients, and assess improvements and impact.

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shared care

mation on how to bring the PRR initiative to your area, please contact us at shared_care@doctorsofbc.ca, or e-mail Dr White at kjwhitedoc@gmail.com.

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MU5 enables community collaboration. With quality data at their fingertips, family physicians and specialists can more readily share care. As other systems mature, physicians will be able to collaborate with multidisciplinary teams, hospitals, and allied community care. Aggregated practice data can support the work of Divisions of Family Practice in their communities as well as provincial initiatives like A GP for Me.

The 31 March 2015 deadline for BC physicians to achieve MU3 is not an end in itself. Physicians who put MU3 to work in real time will see the greatest return on their investment of time, with improved practice efficiencies and patient care in the years to come.

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Reference

1. Hobson B. EMR use in BC: The future is now (part 1). BCMJ 2013;55:415.

billing tips

Audit tip: The 5-year audit period

Many physicians are not aware of the 5-year audit period; almost none are aware of extrapolation and what that means.

While there will be a specific trigger for your onsite audit, did you know that when the audit is conducted on your practice the medical inspector will look at all entries in the medical records? Did you know that the total errors identified during the audit are extrapolated over the entire 5-year audit period?

During an audit, a statistically representative random sample of services billed is established and the medical records reviewed by the medical inspector. If the medical record does not support the fee billed or supports a lesser fee, then that service will be adjudicated by the medical inspector as an error. An error rate for the sample is then established, and that error rate is extrapolated to all the services billed during the 5-year audit period. What this means from a practical perspective is that errors found during the audit may result in a request for recovery. Audit recoveries can be substantial. To put this in perspective, we will use the following example of an audit that was triggered by high counseling visits.

Dr A, a busy urban physician, has MSP billings over the 5-year audit period of $1 800 970.54. Dr A has been inappropriately billing counseling visits when the documentation only supports an office visit. He also has multiple missing records. After giving Dr A credit for the office visits, Dr A's total error rate based on dollars is 18%. The error rate is then extrapolated, using statistical tools, to all the billings over the audit period. The result will be a quantification of approximately $320 000.

This is why it is important to make sure you are billing correctly and documenting what you do. Could you afford to pay this amount of money back? Do not assume that because you have been paid for the services you have billed that you have billed them correctly. If you are unsure of what to bill, call Doctors of BC.

—Keith White, MD, Chair, Patterns of Practice Committee

This article is the opinion of the Patterns of Practice Committee and has not been peer reviewed by the BCMJ *Editorial Board. For further information contact Juanita Grant, audit and billing advisor, Physician and External Affairs, at 604 638-2829 or jgrant@doctorsofbc.ca.*