The Perfect EMR

"Vote for Pedro and all of your wildest dreams will come true" – Napolean Dynomite

I had a dream last night. I dreamt that I had the perfect EMR.

My EMR was written by physicians for physicians. The physicians who designed my EMR were busy clinicians who typically saw 25 patients per day. It was designed to help me do my job better, help me take better care of my patients and get me home earlier so I could enjoy more time with my family and my hobbies.

It was designed to give me constant feedback so I could improve as a physician. I had the ability to measure, monitor and manage the care I delivered so I could incorporate Total Quality Management and Quality Improvement Techniques into my practice.

My EMR provided coding support so I would code properly for maximal reimbursement that was supported and justified by the care I delivered and by the medical record documentation.

My EMR interfaced seamlessly with my Practice Management System for intuitive scheduling, intra office messaging and effective billing.

Since all of my Paper Medical Records were scanned and indexed and stored in a digital format, my staff no longer pulled charts, filed charts or looked for lost charts. My electronic charts were conveniently available anywhere/anytime and they never were misplaced or difficult to find. I easily accessed all the information in these electronic charts during each patient interaction (visit or phone call). We had an off-site back up system in case our server malfunctioned or was damaged by fire, flood or other natural disaster.

The room that I had used to store my paper charts had been converted into another examination room so I could accommodate seeing more patients and I could bring in ancillary services to earn additional income.

My EMR made charting at the point-of-care simple and efficient. I spent less time charting then I had spent with the paper chart that gave me more time to spend interacting with my patients. I was able to review all labs, tests, reports and consultations with the patient at the time of the visit. The relationships and the experiences I had with my patients were enhanced by my EMR, not affected in an adverse manner.

When I left the room after a patient visit, my note was finished, the prescriptions were sent to the patient's pharmacy and the patient was handed a set of printed instructions that summarized the discussions we had had during our visit and listed the "things to do". If a note was needed for the patient's work or school, this was generated and handed to the patient at the point-of-care. My ICD-9, CPT and E & M billing codes were send to my billing department for processing.

In addition, I was able to generate reports required by my insurance companies and Medicare so I could qualify for pay-for-performance initiatives and Medicare incentive bonuses. My EMR was certified by CCHIT and it qualified for "meaningful use". I looked forward to my $44,000 rebate starting in 2011 and my Medicare incentives.

I had “on-demand” clinical decision support tools so I could use them when I needed them, but they were not intrusive and did not send alerts and warnings each time I prescribed a medication or ordered a test.

All tests, reports and labs were sent directly into my EMR without having to be scanned. My staff was expert at indexing these incoming tests, reports and labs so my electronic chart was easy to use and all information was properly stored for quick and easy access.

I charted using a combination of free text entry, macros and templates. My last note on each patient was brought forward to each new visit so I could keep the old information without rewriting it and I could change the things that had changed. For example, when a cardiac patient came with pneumonia, I would change lung exam from “clear” to “rales at the right base” and I would change the flow murmur from 2/6 in intensity to 3/6 in intensity. The parts of the physical exam, review of systems and past medical history that had not changed, did not have to be reentered or changed. This charting method was quick, accurate and saved lots of time.

Health Maintenance charts were populated automatically so I always knew, at a glance, if the patient was due for a mammogram or a colonoscopy.

My patients with chronic conditions like diabetes and heart disease had special chronic problem charts that enabled me to track and manage the routine care of these conditions. I could see, at-a-glance whether my diabetic patient had had a recent blood sugar, HgAIC, eye exam, foot exam and kidney test. I could see, at-a-glance when my patient with coronary artery disease had last had their cardiac consults, EKG, stress test, echocardiogram and cholesterol checked.

My patients could schedule their appointments using their home computers and the Internet. They could check their labs and test results and they could send me emails over a secure network. Phone calls to the office were handled with our intra office messaging system that enabled my staff to attach the patient’s electronic chart to the messages. This included prescription refills and other phone messages.

One of my favorite features was our Virtual Medical Assistant or Virtual MA™. Demographics, insurance information and medical history intake forms were scanned into our system without having to do any keyboard entry at our office. Our medical assistants loved this feature because it freed them up to do what they were trained to do – take care of patients. I loved it because the information was entered before I saw the patient and it was entered with virtually 100% accuracy. This is a crucial task for fully informed medical care and efficient billing.

My days at the office were much more pleasant because I had a great tool to help me care for my patients. My staff was happy because they had a great system to help them with their jobs. They no longer scrambled to find lost charts and the workflow was much smoother with an electronic chart being passed around rather than a paper charts sitting on desks all over the office. I got home earlier each day to spend time with my family or pursue my hobbies. Patients were happier with our service and our friendlier disposition. Everything was better. This EMR was great!

I woke from this dream feeling great. The next day, I began my search for this perfect EMR. I was looking forward to making all of my wildest EMR dreams come true! It seemed that I could take better care of my patients, have a happier staff, happier patients and derive more satisfaction from my job. In addition, I could get home earlier to enjoy my personal life. It was all good.

In my next article, I will tell you how I found my Perfect EMR.

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