Under My Skin

The Perils of Early Adoption

Now that the Feds are pushing them, there's a lot of buzz about electronic medical records, which most physicians have not yet implemented. I put in computerized patient records in 1989. Bully for me.

Because I'm neither technological nor gadgety, I think I did it to save space and filing time and avoid lost records. The space saving was nice, but I didn't know yet that computers lose records, too.

BY ALAN ROCKOFF, M.D.

The computer firm I dealt with was a one-man show, so a few years later, I decided to advance to a larger operation that promised to do niftier things. Could they save all my old records? Absolutely!

But the "cutover" took weeks, not days. And, oh sorry, all my old records got lost. …

Until they finally found them. When I vented and told them that they had completely disrupted my office life, they said, "Well, we didn't exactly cover ourselves with glory."

Later, our office adopted online scheduling. This was supposed to be nimbler than old-fashioned appointment books. Except when it produced absent bookings and double-bookings and most exciting of all, when it lost schedule changes and left fully booked days when I was out of town. We longed for longhand.

Then there was automated appointment confirmation. ("In your own voice, so it won't be impersonal!") This worked well enough when it wasn't calling a day number at night or a wrong number, or putting off patients who resented being called by a machine.

Still later, we became a beta testing site for a new EMR venture. This firm also offered many fancy things and promised to save my old charts. Which they did, eventually. I decided to stick with them because my nervous system couldn't survive another cutover.

My new system could search for a patient with a single click. At first this took a while: After the click, you could get coffee, write some letters, and find the chart waiting when you got back.

Sometimes the server out in cyberspace lost contact with Houston or slowed to a crawl, at which point the EMR and Internet provider companies blamed each other.

Over the years, many such problems have been addressed and solved. The new EMR products are truly marvels of functionality: charts, scheduling, appointment confirmation, prescription writing, and heaven knows what else.

Now that the bugs have been extracted, you should look into them. Oh, and you're welcome.

My pioneering experiences with another technological wonder, the laser, were similarly successful.

The first lasers I leased in 1993 cost upward of $100,000. Could they remove tattoos? Completely—in four to eight treatments! And so much more!

One laser stopped working in 1994. The lease guy commiserated. "Some people are suing the company," he said. "They claim these lasers are nothing but giant doorstops." Indeed—giant, costly doorstops with multiyear leases.

Hair removal lasers came out in 1997. The first ones shot a 3-mm spot at the rate of two pulses every 3 seconds. Doing a back took a day or two.

And there was the little matter of heat. The hair laser produced so much of it that my landlord threatened to throw me out for destroying his HVAC system.

The laser salesman offered to buy me a room air conditioner. Would that work? He didn't know. The president of the laser company didn't know either.

This laser broke down repeatedly. So did the vascular laser.

By the time technicians came to fix them, disgruntled patients had been canceled or sent home. Revenues plummeted, but lease payments came like clockwork.

Now, of course, it's much different. Lasers are smaller, cheaper, more versatile, and far more reliable. Also, they've been around long enough for both doctors and patients to have a more realistic sense of what to expect of them. This makes for fewer service calls and fewer dissatisfied patients.

New technology can be seductive. The next time an enthusiastic salesperson stops by to tout the latest and greatest and tells you that the new product will save enough staff time to "pay for itself in 18 months" or that this new machine "will take just two treatments a month to cover your lease!" run like mad to the nearest exam room and lock the door.

Then ask yourself whether you're sure this new techno-marvel is really ready for prime time or whether you'd like to wait to let other people do the early adopting so that you can climb aboard when the innovation really does what it's supposed to—and is lots cheaper besides. ■

Dr. Rockoff *practices dermatology in Brookline, Mass. To respond to this column, write Dr. Rockoff at our editorial offices or e-mail him at sknews@elsevier.com.*

Adviser's Viewpoint

Quality Reporting in Dermatology

The Centers for Medicare and Medicaid Services recently unveiled plans for the 2007 Physician Quality Reporting Initiative. The PQRI is intended to reward physicians who choose to participate in and report outcomes of best medical practices. CMS will gather reported data from July 1 through the end of the year, and will pay a single lump sum bonus of 1.5% on all eligible services billed to CMS for those who report all quality measures at least 80% of the time.

BY DIRK M. ELSTON, M.D.

Although major corporations are pushing quality reporting in their employer-provided health coverage and hospitals are applying other bonus payment models, the only quality incentive program in which dermatologists can participate nationally right now is Medicare's PQRI.

Measures for PQRI were developed by each specialty society in cooperation with the American Medical Association Physician Consortium for Performance Improvement. Each was based on currently vetted evidence-based guidelines of care and published evidence of existing gaps in care. All measures went through a public comment period and review by organizations such as AQA, formerly known as the Ambulatory Care Quality Alliance.

Participation in PQRI is voluntary and no registration is required. Dermatologists who choose to report the measures can start any time, but CMS will start to gather data on July 1. The current list of PQRI measures can be found at http://www.cms.hhs.gov/PQRI/.

The three measures that dermatologists may report apply to Medicare patients with a current melanoma or history of melanoma. Using CPT category II codes, you can document that the patient was asked about new or changing moles (1050F), had a complete skin exam performed (2029F), and was counseled to perform a self-examination (5005F).

Those who report all three measures at least 80% of the time will be eligible to receive the 1.5% bonus. The bonus is paid on all eligible Medicare payments received by the physician during the 6-month reporting period.

CMS will determine who qualifies for bonus payments through CPT category II and ICD-9 codes submitted on Medicare claims. Patients whose visits include a diagnosis code for a current melanoma or a history of malignant melanoma will serve as the denominator. The numerator will be the number of those patients for whom the CPT category II codes were reported. Codes do not have to be reported every time the patient is seen, only once during the 6-month period.

There are valid reasons why each measure may not be appropriate for a given patient. For example, a blind patient would not be counseled to do self-examination. An amputee cannot receive a full body exam. Modifiers to the CPT category II code can be used to report these reasons:

► Use the –1P modifier for medical reasons.

► Use the –2P for a patient reason, such as a language barrier.

► Use the –3P for a system reason, such as patients whose melanoma is being treated by another physician.

The era of quality reporting has come to medicine. Although dermatologists' opportunity to participate is currently modest, we can do so by applying a limited number of evidence-based practices to the care of our melanoma patients and receive a modest reward for doing so. ■

Dr. Elston *is the director of the department of dermatology at Geisinger Medical Center in Danville, Pa. He also serves as cochair of the American Medical Association/American Academy of Dermatology Pay for Performance Workgroup.*

PAIN RELIEVERS

"There is a lot that medical science knows but is not telling us."