Easy Adoption Of Affordable EMR in the Small Group Practice

A Practical Guide

Vidya Loganathan MD

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Introduction:

It has been observed that small group practices are often reluctant to adopt the use of EMR (Electronic Medical Records) in their practices. Common misconceptions associated with the implementation of an EMR system include increased work load, complicated software, and additional cost with no financial benefits to the physician or increased staff and patient satisfaction.

This white paper highlights some of the obstacles small practices face, reviews current EMR market trends, addresses practical methods to overcome obstacles and identifies financial improvements associated with a successfully implement EMR in a small practice.

EMR market:

EMR software typically varies from a simple notes builder to a complete enterprise workflow management system. A comprehensive EMR system should contain the following components:

1. Clinical documentation & decision support
2. Workflow management including scheduling
3. Diagnostics & referral management
4. e-Prescription
5. Communication including faxing & messaging
6. Patient portal
7. CCHIT Certification

Most EMR Systems are integrated with Practice Management System (PMS) and can interface with other practice management systems to provide a smooth flow of data.

EMRs certified by CCHIT (Certification Commission on Healthcare and Information Technology), are designed to strict standards and have overcome issues related to data security, privacy protection, and interoperability with other health care data providers. It should be noted that all EMR systems on the market are not certified by CCHIT and that CCHIT certifications are valid for three (3) years.

The cost of an EMR system can vary drastically, often exceeding tens of thousands of dollars. In addition to licensing costs, the cost of deployment including installation, training and support and hardware costs will impact the TCO (total cost of ownership). Depending on the type of system selected and the vendor, licensing costs may require significant upfront payments or may allow for lower monthly subscription payments.

Today it is practical and financially affordable to deploy EMR for a small group and solo practice. The net return on investment in financial and clinical terms is the highest it has even been.

Current trends:

The federal government is actively promoting the adoption of EMRs. Recent policy decisions have been designed to remove barriers and incentivize the transition to the use of **E**lectronic **M**edical **R**ecords. PQRI (Physician Quality Reporting Initiative) and the e-Prescription 2% bonus by Medicare are initiatives that are expected to increase the EMR adoption rate (amednews.com). It is predicted that by 2013, most physicians will have migrated to EMR improving workflow efficiency and the quality of clinical care.

EMRs certified by CCHIT in the market today are offered at several levels of affordability. Numerous specialty associations have sponsored initiatives that promote adoption of EMR systems within their specialties. The largest of the specialty associations, the *American College of Physicians*, has initiated an effort to evaluate and present various options to adopt. The ACP has specifically targeted EMRs suitable for their small group and solo physician members.

Common obstacles and solutions:

Lack of in-house IT expertise

Most small practices do not have a dedicated IT staff to handle software and hardware issues in-house. When EMR is deployed, uptime of the EMR system is critical to proper practice function, unlike a practice management system that can be bypassed temporarily in the patient work flow. It is recommended that when selecting an EMR System, access to reliable experienced IT support is available from the vendor.

ASP Model

Today's technology has alleviated the risk of downtime and system cost with the implementation of the **ASP** (Application Service Provider) model. In this EMR model the software is hosted and maintained in a secure and protected environment of a hosting service. Levels of security vary and it is important to select a vendor offering:

a. SSL 128 bit encryption protocol and 1024-bit public keys (the same level of security banks use to transmit secure financial data online).
b. A unique identifier password and account id.
c. Integrated redundant model to avoid unnecessary downtime.
d. A data center protected by sophisticated firewalls and intrusion systems.

The physician's office requires:

a. Broadband internet access.
b. A computer (desktop, a laptop or tablet PC).

The need and cost to maintain the software, server and form backups is eliminated. The secure EMR system can be accessed from anywhere including satellite locations and hospitals.

Installing and maintaining a simple network to access the internet is as easy as maintaining a home computer network. With reliable broadband widely available and the low cost of desktops and tablets,

the **ASP** model is a very practical and viable option. Physicians can further protect their data by making a periodic backup of their patientôs charts for in-house storage or to an external backup service provider like mozy.com.

A proper contingency plan must be created, documented and available to the staff to handle rare system downtime. Several techniques can help alleviate practice disruption including:

a. Printing the patient scheduler chart summary at the beginning of the day
b. The use of paper documentation during disruption.

Should the office EMR system be disrupted, patients can be still be seen and documented on paper until the situation is resolved. Once the system is back online, the paper document is simply scanned into the patientôs chart to record that visit.

Transition of work flow and paper charts to EMR

There are several methods to ease the transition to EMR without slowing down the office. Successful transitions typically involve:

a. Each staff member practices a work flow session with the help of vendorôs online or onsite training team and develops a cheat-sheet of their common tasks. It is ideal to keep the training sessions online and spaced apart to assimilate the software thoroughly.

a. After each staff member is oriented with the EMR, choose a few patients each day to document in EMR. The patient sets can be new patients seen in that day, the last few patients of the day or patients scheduled for a particular type of visit e.g. physicals, vaccination etc.,

b. After two weeks of transition sessions, go live on EMR for all patients. Ensure the vendor is available to help with any glitches.

When moving an existing patient to EMR:

a. Scan the relevant portions of the paper chart prior to the visit (the day before the scheduled visit is optimal). Note - It is not necessary to scan the whole document. Typical portions of old chart that are scanned into the EMR are:

    i. Last visitôs notes
    ii. Problem list (documenting the conditions and key clinical parameters of the patient)
    iii. Any significant outside report.

b. After scanning the relevant paper chart extracts to the EMR, the old chart can be left in the examining room for the physician to review & mark any additional pages for scanning. Once the first visit is documented in EMR, the paper chart can be marked for archival and storage.

Slowdown of patient volume during EMR transition

It is not uncommon to experience an initial slowdown in the patient volume during the transition from paper to EMR. These can be mitigated with solid planning, comprehensive training and a graduated phase-in of EMR features.

Most front-desk and nursing staff experience significant increased productivity immediately upon EMR deployment. This productivity improvement is attributed to the elimination of the retrieval, routing and storage of paper charts. Computerization of these tasks simplifies and improves staff work flow while enhancing job satisfaction.

The major concern during any EMR deployment is the clinical documentation by the physicians. If ambitious templates are attempted at implementation, it is likely to slow down the patient flow process and jeopardize the deployment. Generally, physicians who are not computer savvy experience difficulty in accessing and documenting electronic charts. To eliminate any slow down with the physicianôs role in the EMR, the following measures can be adopted:

a. Start with the simplest template possible. Non computer savvy physicians can use handwritten notes templates on a Tablet PC similar to a paper chart. The only difference between writing notes on a paper and writing on a Tablet PC is that the Tablet PC records the notes electronically eliminating the step of filing and potentially misplacing the notes.

b. Transition to advanced features in a phased manner. Various modules like e-Prescriptions, electronic lab results, referral generation etc., can be done at a pace comfortable to each physician.

c. Some physicians find it easier to annotate notes during the visit on a paper or electronically and complete the documentation after all patient visits are done.

Practice Benefits with implementation of an ASP model EMR system

Financial benefits are immense ï direct savings in supply costs, labor savings in charting duties, elimination of loss in charge capture and financial incentives from payers can increase a physicianôs revenue and profit significantly.

Potential savings EMR <u>per FT M.D. per annum</u>: (Source AAFP, American Medical News)

Chart Supplies	7,000
Transcription Costs (if using transcription)	15,000
Clerical Labor Costs (Filing and Workflow) 0.3 FTE	10,000
Filing and Storage Costs	2000
Additional Patient Visits- minimum 1 per day	25,000
Total Tangible Benefit	**$44,000 -$59,000**

Clinical benefits tremendously enhance patient care ï lab results are not missed, prescriptions errors are reduced, clinical monitoring of vital health parameters are enabled, and messages are tracked to name a

few.

Conclusion:

With the right choice of an ASP EMR system, proper planning and training, EMR deployment in a small group practice / solo practice can be financially and clinically rewarding.

Dr. Loganathan is a board certified internist with a group practice in Waterbury and has been in practice for over 14 years. Her practice has been an early adopter of EMR in 2002 and has experienced significant workflow improvements, financial return and improved staff and patient experience levels.