



**Health Directions**

*Business solutions for healthcare organizations*

## **A 360-Degree Approach to EMR Implementation**

**Daniel J. Marino**  
**Health Directions, LLC**

# Agenda

- Environmental Overview
- Information on the HITECH Stimulus Opportunities
- Hospitals, Physicians and Interoperability
- Preparing for an EMR Implementation
- Project management and the EMR implementation
- Case study

# EMR Trends in Health Care

- The U.S. spent over \$2.2 Billion in health care in 2008, yet most of the information exchange is rudimentary
- According to the CDC's National Center for Healthcare Statistics 2007 survey, only 25.9% of medical practices had some form of EMR
- U.S. is adopting EMR technology at a much slower rate than other industrialized nations
- According to a 2007 study conducted by the Institute of Public Health, Physicians who use electronic health records believe "(EMR) systems improve the quality of care and are generally satisfied with the systems"

# Government's Role in Promoting EMR Technology

- Promoting incentives for quick implementations of EMR in medical practices
- CMS is paying incentives to physicians for reporting quality data using EMR
- Since early 2005 the Department of Veterans Affairs (VA) Hospitals have been adopting an EMR
- Proposed bills introduced to incorporate EMR technology within all physician offices over the next 3 years
- HHS Secretary Mike Leavitt is promoting EMR technology as means of change reimbursement and slowing the rise in health care spending

# Proposed Reimbursement Changes

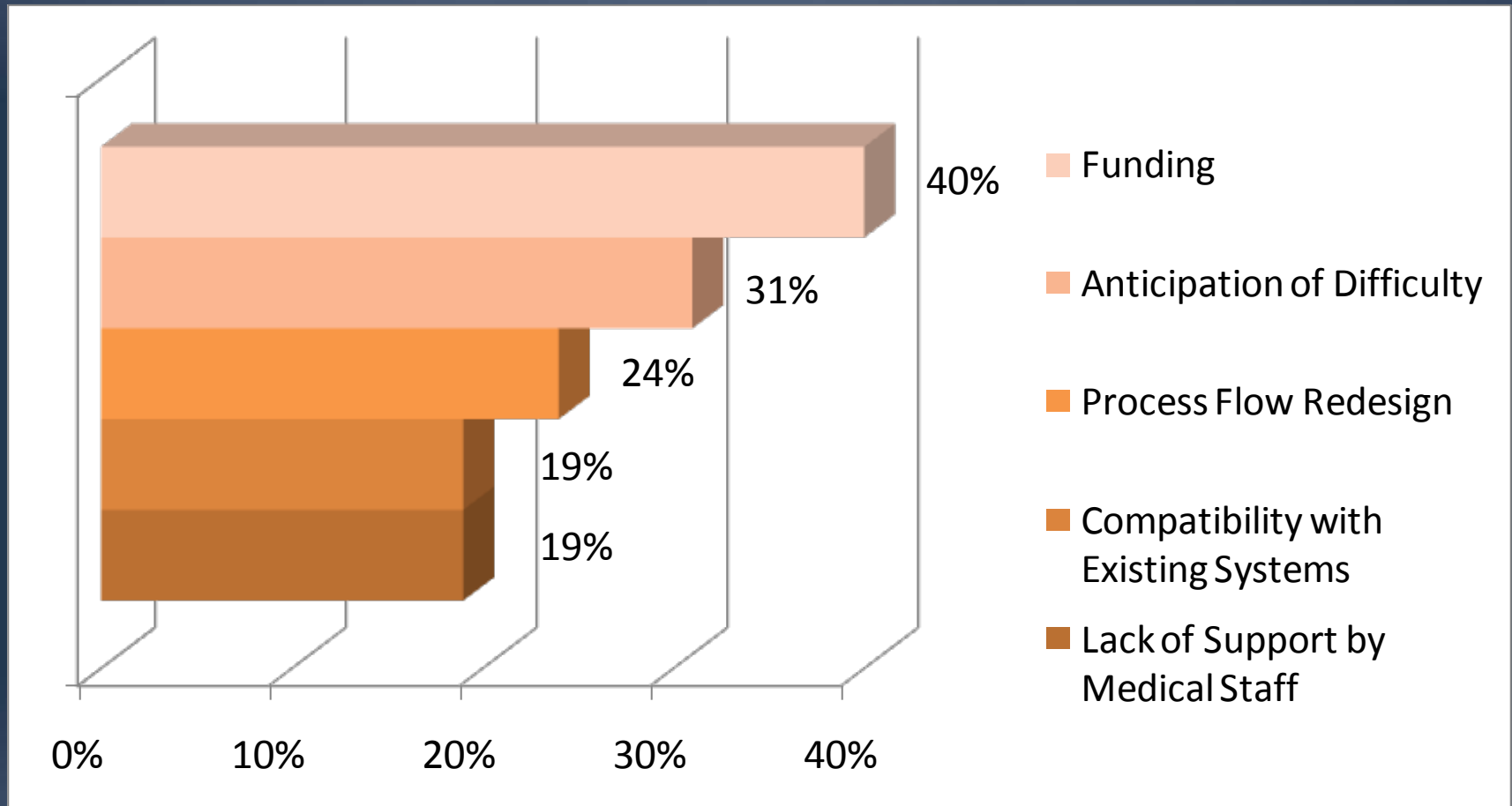
- Government's position on reducing cost is to tie provider reimbursement to quality data and outcomes
- Medicare (CMS) already began quality based reimbursement with the PQRI program
- Some plans are beginning to follow the government's lead

# What We Hear as Reasons to Not Implement and EMR

- Costs are too high
- Electronic health technology will interfere with my office workflow
- An EMR will slow me down, I'll see less patients
- I'm going to wait to see the "technology direction" of the hospital
- A huge undertaking and may not practice much longer



# Most Common Barriers to EMR Adoption



\*MRI 2007 Survey of Electronic Medical Records Trends and Usage

# Eventful Times: The Need for Electronic Health Technology is Now

“This will cut waste, eliminate red tape, and reduce the need to repeat expensive medical tests.

It just won't save billions of dollars and thousands of jobs -- it will save lives by reducing the deadly but preventable medical errors that pervade our health care system.”

- President Obama



# American Recovery and Reinvestment Act of 2009, H.R. 1 (ARRA)

- This legislation includes over \$19 billion in funding for health information technology (HIT) infrastructure and adoption. Additional allocations for training, research and quality increasing the total funding for health care initiatives to over \$59 billion.
  - Health Information Technology for Economic and Clinical Health Act (HITECH) provides \$19.2 billion in funding for HIT.

# Breakdown of \$19 Billion

**\$17 billion Physician Incentives**  
Incentive Bonuses from Medicare/Medicaid

**+ \$2 billion HHS Discretionary Funds (For Use By National Coordinator of Health IT)**  
Standards Development, Grants (AHRQ, HRSA, CMS), HIE Infrastructure, Loans to the States for EHR, Regional HIT Resource Centers, Telemedicine, Efficacy Studies

**= \$19 billion**

HHS = Health and Human Services

AHRQ = Agency for Healthcare Research and Quality

HRSA = Health Resources and Services Administration

CMS = Centers for Medicare and Medicaid Services

# Health Information Technology for Economic and Clinical Health Act (HITECH)

- \$17 billion in incentives require proof of "meaningful" use
  - Use of a certified product as determined appropriate by the Sec. of HHS
  - The EHR technology must be connected
  - Complies with submission of reports on clinical quality measures
- “Early Adopters”, those that adopt first will benefit the most (declining incentives)
  - Physicians can earn between \$44,000 to \$64,000 over five years from Medicare / Medicaid if they are utilizing an EHR in 2011
    - Late adopters will receive significantly less
    - Providers may receive incentives under only one of the programs
    - 2015: reductions in Medicare/Medicaid fees for non-EHR users
- Hospitals can earn up to \$2,000,000 *plus discharge bonuses (total payout to them could be \$10 million +)*

# Medicare Incentive Payments

- Medicare incentive payments will be available to “eligible professionals and hospitals” for the first five years 2011-2015
  - If eligible professionals and hospitals do not demonstrate meaningful use by 2015, Medicare payments will be reduced
- First Payment Year
  - \$18,000 if the first payment year is 2011 or 2012
  - \$15,000 if the first payment year is 2013
  - \$12,000 if the first payment year is 2014
- Second Payment Year: \$12,000
- Third Payment Year: \$8,000
- Fourth Payment Year: \$4,000
- Fifth Payment Year: \$2,000

# Medicaid Incentive Payment (State/HHS)

- This section authorizes States to pay Medicaid providers no more than 85% of the net average allowable costs for certified EHR technology (maximum of \$64,000 over 5 years). Secretary of HHS is to study costs of EHR and determine the “net average cost.”
- Eligible Medicaid providers must first demonstrate use by 2015 and eligibility for incentive ends after 2021
- Eligible providers include:
  - Non-hospital based pediatrician with at least 20% of patient volume receiving medical assistance (Medicaid)
  - Children’s hospitals or an acute care hospital that is not a children’s hospital that has at least 10% of the hospital’s patient volume attributable to individuals receiving medical assistance

# Additional Incentives Continue

- Physician Quality Reporting Initiative (PQRI)
  - Eligible Medicare providers who satisfactorily submit quality measures data will earn a 2% incentive payment
- E-Prescribing
  - The E-Prescribing Bonus Program allows eligible Medicare providers to receive incentives for use of qualified e-prescribing software between 2009 and 2013
  - 2009: 2% incentive based on allowed charges for all Physician Fee Schedule (PFS)
  - 2010: 2%
  - 2011: 1%
  - 2012: 1%
  - 2013: 0.5%

# Hospitals are Supporting Physician with EMR

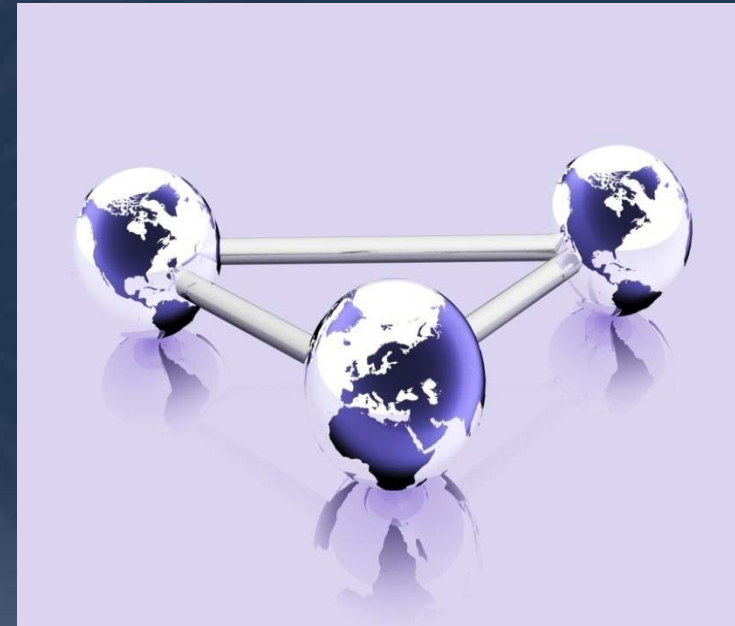
- Hospitals are creating electronic health networks for community physicians
- Hospitals, PHOs and IPAs and negotiating on behalf of employed and community physicians
  - Relaxation of Stark regulations are allow hospitals to provide EMR technology to physicians
  - EMR due diligence process is performed by physicians
- Hospitals are providing interoperability and interfaces for physicians
- Health Information Exchange Regional Grants
  - \$300,000,000 for regional efforts toward health information exchange
  - Regional Health Information Organizations
  - Health Information Exchanges
  - Regional approach

# Summary of Incentive Opportunities

- \$44,000 to 64,000 available per physician over 5 years
  - \$30,000 of \$44,000 is available during the first 2 years (2011, 2012)
- 2% reimbursement of Medicare revenues available from CMS for PQRI reporting
- 2% reimbursement available from Medicare available for e-prescribing
  - Reimbursement begins to decrease in 2011

# The Direction EHR Technology

- Promote electronic health technology within physician practices
- Electronic health networks and interoperability platforms are the future of technology
- Allow for efficient and safe transfer of health information



# What is Interoperability in Healthcare?

- The ability for EMRs to electronically share data and communicate with one another
- The systemic exchange of patient health information
- The exchange of patient health information between entities, providers, patients, health plans, pharmaceuticals and laboratories
- Regional health information organizations as a means of centralizing patient data exchange for communities

# Hospital-Physician Relationship and Electronic Health Technology

- Electronic Medical Records, interoperability and clinical performance outcomes can drive revenue
- Clinical outcomes are becoming a bigger part of reimbursement and quality of care (clinical integration)
- Electronic health technology improves patient care through documentation, coding and reduction of errors
- Pay for performance and evidence based reimbursement will drive future managed care contracting strategies

# Community Health Integration Strategy

- Electronically connecting hospitals, IPAs, physicians, patients, payers, labs, pharmacies, into a secured digital networks
- Many stakeholders, but hospital and physicians will take the lead
- Allow for a secured efficient transfer of medical information between entities
- Provide patients with new “healthcare conveniences” through the use of technology
  - Web portals
  - E-mails
  - Text Messaging

Key success of any community health initiative is ensuring the physicians *use* the technology....it begins with EMR

# Successful Components of an EMR

## Best Practices

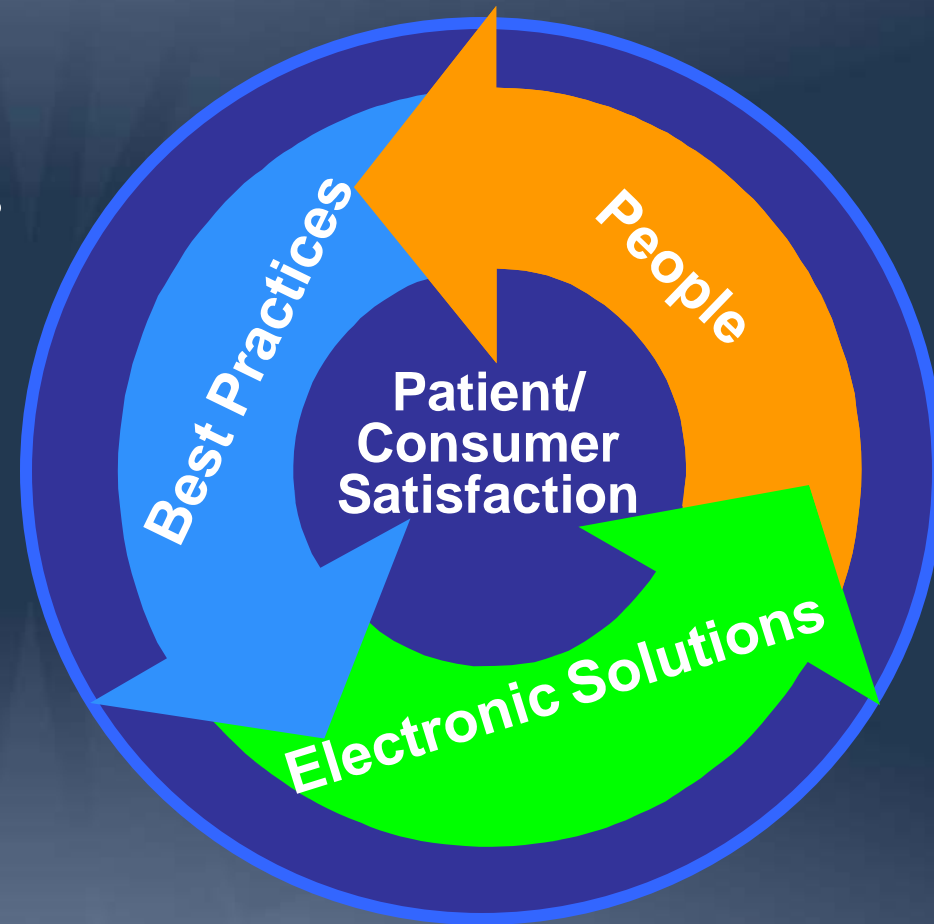
- Clinical workflows
- Revenue cycle processes
- Standardized policies, procedures and work flows

## People

- Staff training and education
- Measure outcomes and tracking
- “Patient-focused” approach

## Electronic Solutions

- Practice Management
- Electronic Medical Record
- Business Intelligence



# Return on Investment (ROI) of an EMR

## Revenue Opportunities with an EMR

- Improved accuracy of documentation most of the time leads to better coding, more revenue
- Increase in charge capture of services and improvement accuracy of claims
- Negotiate quality performance outcomes within payer contracts
- Reduce redundancy of diagnostic testing
- Financial Incentives for early adopters

# Return on Investment (ROI) of an EMR

## Anticipated Savings

- Time and motion studies
  - Cost of charts pull, phone triage, messaging
  - Test results processing
  - Form completion
    - Immunizations forms, etc.
  - Prescription re-issue
  - Chart creation
- Average of cost of staff
  - Patient phone calls
  - Rx refills and pharmacy calls
  - Referring physicians requests
  - Insurance information and referral/pre-cert processing

# Anticipated Savings with EMR

- Areas of real savings:
  - Transcription cost
  - Chart creation
  - Physical storage space
  - Medical records FTE
  - Encounter forms
- Time spent looking for lost charts, transferring charts and coding tickets
- Efficiencies and lower costs associated with Rx refill
- Printing of patient education materials

# Success Criteria Of EMR Implementation

- Design EMR technology to allow physicians to incorporate “easy-to-retain” functionality as well as clinically intuitive pathways
- Redesign clinical workflows that promote automation and efficiencies
- Don't forget your revenue cycle
- Adopt an incremental deployment strategy in order to increase comfort level and build confidence in EMR
- Adopt the IDDUINEM principle in building the appropriate content
  - *If Doctors Don't Use It, Nothing Else Matters*

# Implementation Concepts as You Build Your Work plan

- Incorporate the 80-20 Rule in your system design
  - Avoid designing a solution for 20% of the cases
  - Focus on the 20% of cases that represent 80% of your solution
- Create your project team based on expertise and communication
- Project management is critical to your success
- Engage your physicians and key influencers
- Prepare to test and train
- Develop your implementation infrastructure

# Physician Involvement

- Common mistakes to avoid
  - Overestimating physician confidence with electronic solutions
  - Under involvement of physicians in the EMR selection and the consensus building process
  - Limiting the physician involvement in the design and implementation phases
- Design the electronic process around the exam room encounter
- Templates and tasks need to support the physician's specialty and not a generic electronic note

# Consider Changes From The Paperwork Workflow Process

- The paper chart versus electronic templates
  - How is the chart set-up and organized for different patient visits?
- Incoming lab and ancillary results
  - Need to consider how they are incorporated into the electronic record versus review and sign-off
- Process to notify patients of results
- Leverage electronic technology with faxes, scanning and e-mail
  - Consideration to HIPAA and patient confidentiality

# Document Conversion

- Need to create a plan for conversion of records and incoming information
- Are their archived transcription files?
- Consider how far back in time to begin the patient record conversion
  - 3 year history
  - Appointments for the next 6 months
- Scanning of current and new patients
  - How much of the chart and how far back?



# Consider New Ways to Manage the Revenue Cycle

- Evaluate how you managed your Revenue Cycle before an EMR implementation
  - Was/Is it effective?
- Were you effectively using your Practice Management System and/or Business Intelligence tools to manage?
- What tools does your EMR offer to manage the functions you implemented?

# Case Study

# Background

- 10 provider group practice with 3 clinic locations
- Large amount of managed care contracts and 30% governmental payers
- Few reports were used to manage revenue cycle functions
- Practice management system was underutilized
- The revenue cycle activities required automation and efficiencies in order to maximize outcomes

# Implementation Strategy

- Selected a powerful and well respected EMR Vendor
- Phased approach to design and implementation
- Implementation lacked physician input
  - Many of the staff had little working knowledge of EMR
  - Most staff tasked with designing EMR had little knowledge of clinical or revenue cycle operations
- Most physicians were reluctant to adopt EMR, despite a directive from leadership that adoption was mandatory

# Outcomes at Go-live

- Lack of workflow redesign led to many operational inefficiencies
- Rather than scan at the clinic sites, all documents were batched and sent to the Business Office, leading to misplaced documents that were often scanned to the wrong chart
- Physicians reluctance and a directive from management to adopt, led to the design committee pacifying physicians rather than implementing the solution to its fullest

# Outcomes at Go-live (Con't)

- Many of the template and edit features of the EMR were disabled for fear of “disrupting the physician’s ability to see patients”
- Features designed to facilitate coding and correct charge capture on the front end were under utilized creating a bottle neck of errors in the business office
  - ROI on staffing in the clinics were countered with an increased need for staff in the business office to manage charge capture process

# EMR Intervention

- Refocused the design team to include a physician champion with a strong clinical support person
- Created detail clinical process flows to identify areas of efficiency and automation
- Implemented e-prescribing with all providers
- Created templates around the physicians practice style allowing for coding and documentation efficiencies

# Current State

- Physicians began to realize efficiencies with EHR technology
- Completed a process redesign of the entire revenue cycle
- Automated many of the manual processes that remained after the go-live
- All Clinical documents are now scanned at the office site
- Physicians went through a reeducation process of clinical workflow and EMR benefits to change attitudes and behaviors
- After 3 months, the EMR begin to contribute to improve revenue for the practice

# Where do you go from here?

- Talk with colleagues and APP to assist with decision making
- Give serious consideration to the hospital preferred vendor solution
- Your decision will come based more about “when” to implement and not “if”
- Begin thinking about your practice’s strategic goals and implementation objectives
- Network, network, network
- When it finally comes down to moving forward, it’s really not about the technology, it’s about the clinical processes and workflows

# Questions