Automating a Group Practice as a Team Effort: Selecting and Implementing a Practice Management and EHR System

A case study

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This paper is being submitted in partial fulfillment of the requirements for election to Fellow with the American College of Medical Practice Executives.
INTRODUCTION:
A 4-physician single-specialty group leaving a larger multi-specialty practice and starting their own private practice needed to select a Practice Management (PM) and electronic health record (EHR) system by April 1, 2013. While the new corporation was established the summer before and health plan contracts were in place, the actual decision to leave the larger multi-specialty practice and the terms of departure were not finalized until early February of 2013. While some background work took place in setting up the practice over the months, it was never official that the practice would be leaving the larger multi-specialty practice until early February. Once that decision was made, there was a lot of work to do in a short period of time. The practice had less than 2 months to get up and running in a new setting, with an independent schedule and billing system. The practice administrator was tasked with assisting the group in building consensus around the needs for a combined practice management and electronic health record (EHR) system that would meet the needs of the group’s business in their own private practice.

To be considered a successful outcome, all physicians had to achieve buy-in on the system selected and the system had to be fully operational with staff and providers trained by April 1, 2013. The physicians had determined a budget of $10,000 for start-up fees and consulting expenses, and did not want to pay more than $600 per physician per month for the ongoing operational expense of running the software. The practice administrator had to involve the physician stakeholders in all major decisions, and keep them apprised of milestones in implementation of the system.
The practice was opening its doors on April 1st and could operate manually, with hard-copy encounter forms and printed claims. However, this would have a material negative impact on the efficiencies of the staff and providers as well as the cash flow (since paper claims delay payment relative to electronic submissions). The physicians and administrator had time before the doors opened to investigate the choices and receive training on a system. Once the practice was operational, the time that could be committed to this labor and time-intensive task would be non-existent and less of a priority.

Given the current incentives (and penalties) from government payors to automate a practice (meaningful use, e-Prescribing, and PQRI), the practice would forego incentive funds, and lose real money for not automating its medical records and prescriptions. In addition to lost revenues, transitioning from a paper system to a new EHR later might add risk to the high quality of care provided to the patients.

Bringing in a new PM/EHR involved many stakeholders and required a dedicated team approach. It involved the physicians, practice administrator and her staff, as well as the outside billing manager and her staff. The primary champion was the practice administrator, although there was an interim chief executive officer (CEO) who was updated by all parties regularly and met weekly with all physicians to give updates and receive direction on necessary decision points. The assembled team had no experience in starting a physician practice from scratch, and had never selected a PM/EHR before. The practice administrator and billing manager had the most work to do, and established timelines and checklists based on their prior practice management experience and research on the topic to guide their endeavors. They worked closely with each other, and directed the activities of an information technology subcontractor, who was invaluable in the selection and set-up of the software.

Hundreds of hours were spent in a very short period of time to get the practice up and running within the physicians’ established budget and timeframe. This accomplishment could be reproduced by other practices under similar conditions, and this case study is a look at how one practice succeeded in a successful automation of a new private practice.

**A DETAILED LIST OF DECISIONS USED TO CHOOSE THE SOLUTION:**

When discussions first took place about the physicians leaving the large, multi-specialty practice and entering private practice, the practice administrator first scoured the marketplace for a Healthcare Information Technology (HIT) consultant with experience assisting small physician groups with successful implementation of a variety of Practice Management/EHR platforms. The consultant was identified by recommendations of a business consultant, references were verified, and an engagement agreement was counter-executed in October 2012 (Figure 1). The HIT consultant would receive a
$3,000 fixed project fee, reducing the total budget to $7,000 for remaining start-up expenses.

Based on input from the HIT consultant, it was determined that the first decision that needed to be presented to the physicians was whether or not to purchase the license to a system, such as Medical Manager or AllScripts and own it outright, or lease a cloud-based solution for less financial outlay and long-term commitment, but no ownership. A prior administrator, who was not familiar with cloud-based solutions, had recommended the physicians spend the upfront money (tens of thousands of dollars) to own the system and have control over it. The physicians were predisposed to think this was the only way to proceed. The physicians, however, were swayed by the advice of the HIT consultant that the lack of investment in the hardware allowed the practice to change platforms more readily if they wanted to upgrade to a newer, better cloud-based system in the future. “Renting” the software would deprive the physicians of much customization of the EHR, however this was deemed a non-essential consideration relative to the cost of owning the software outright. To obtain a system that allowed complete personalization over time – either in a licensed or cloud-based arrangement – was cost-prohibitive. The physicians liked the lack of the upfront cost, as well as the lack of a massive commitment by investment in one solution, and achieved consensus around the cloud-based solutions.

The decision to go with a cloud-based system was a helpful one in determining an EHR as it greatly reduced the number of platforms that would be researched. With this directive, the practice administrator and HIT consultant were able to survey other practice managers in the community on systems they were using and compile a list of potential software vendors for the physicians’ consideration. It was decided by the physicians that the PM/EHR solutions selected by the practice administrator and HIT consultant would be presented at the next physician meeting in November 2012 (Figure 1).

CREATING A YARDSTICK FOR MEASURING EHR/PM SOLUTIONS:
To narrow the scope of available PM/EHR systems for the physicians’ consideration, the Practice Administrator, with the help of the HIT consultant, created a “yardstick” for measuring the various tools, relative to the practice’s needs. These were agreed-upon “must have” features that any system would need to meet the needs and garner the buy-in from each physician. This incorporated all feedback from the physicians to this point on what they considered essential in the software based on their prior experiences with other systems, and their anticipated future needs.

The practice needed:
- A system that was certified for meeting meaningful use.
- A system that allowed for electronic prescribing.
• An integrated solution that coupled the EHR with the PM. In other words, the front-end practice schedule from the PM system would link directly to the EHR tool for the physicians’ documentation. This integrated solution was more desirable than, for instance, using an EHR and PM that didn’t collaborate, and creating a virtual bridge between the two systems. The physicians desired more of a turn-key solution.

• Schedules that could:
  o vary appointment times by provider. In other words, if one provider wanted a 40-minute new patient appointment time slot, while another physician wanted 45-minutes, both had to be accommodated in their respective online schedules.
  o allow the physicians to schedule remotely, for example, from their iPhones. The physicians wanted to view, and add to, their daily schedules remotely.
  o combine the physicians’ personal and professional calendars, specifically allowing the physicians to include Outlook calendar items from their personal calendars. One of the downfalls of the multi-specialty group’s EHR that the physicians were familiar with using historically was that they had to keep their personal schedules separate from the practice schedule. This was a hassle for the front desk when scheduling patients because they only knew the physicians’ professional schedules, and not their personal schedules.

• Documentation that:
  o included templates that could be customized for each provider. Within the specialty practices, the physicians had distinctly different patient populations. What would work for an exam element for one provider would not extrapolate to another. Thus, all 5 physicians wanted diagnosis drop-downs and documentation templates that work for their unique patient populations.
  o would input the physicians’ Dragon Speak for dictation, and allow for open-ended Notes’ space for adding whatever else they wanted to include in the patient medical record (beyond the defined drop-down lists).
  o would upload and store, for easy access, pictures of patient surgeries. This was critical for the physicians when they were on-call for one another. They wanted to be able to visualize the incision and the operation performed when handling patient inquiries for a physician partner’s patients post-surgery.
  o incorporates lab and x-ray reports from multiple sources into the unique patient record.

• The physicians also wanted the EHR to recommend or provide a CPT/HCPCS code, and prompt them for modifier application when necessary, based on the medical documentation just entered.

The physicians were presented with 5 PM/EHR software solutions that met their pre-established ‘yardstick’ features.
Alternatives Considered:
The solutions presented to the physicians in mid-November 2012 met all of the “must have” features. The additional information provided was the cost data for start-up and ongoing monthly expenses, which all had to fall into the budget of $10,000 ($7,000 net IT consulting project fee) upfront and no more than $600 per physician monthly:

<table>
<thead>
<tr>
<th>EHR/PM Option</th>
<th>System Acronym</th>
<th>Set-up Fee</th>
<th>Monthly Fee per Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>#1:</td>
<td>DMA</td>
<td>$6,000</td>
<td>$430</td>
</tr>
<tr>
<td>#2:</td>
<td>KPF</td>
<td>$5,000</td>
<td>$299</td>
</tr>
<tr>
<td>#3:</td>
<td>CCA</td>
<td>$2,000</td>
<td>$499</td>
</tr>
<tr>
<td>#4:</td>
<td>SRW</td>
<td>$6,500</td>
<td>$600</td>
</tr>
<tr>
<td>#5:</td>
<td>PCI</td>
<td>$5,000</td>
<td>$400</td>
</tr>
</tbody>
</table>

The physicians were presented the features and capabilities of each of these 5 products in a written report prepared by the practice administrator. The physicians were asked to narrow the list down to 2 or 3 products for further exploration and demonstrations. By starting with a detailed list of requirements, it was much simpler for the administrator to demonstrate that all options would meet the needs of the physicians. This, in turn, minimized any disagreements and overall the physicians were pleased with their choices. The new, and ultimately, determining factor became whether or not another practice of a similar specialty was using the system. The physicians wanted to speak with the vendors who had experience with their specialty, and to speak to references of the same specialty to check their satisfaction.

Chosen Solution:
Based on calls with the sales representatives from all 5 companies, the list was narrowed down to 3 that had experience working with the same specialty of the physicians in the group. The final 3 software solutions as selected by the physicians were: #1 DMA, #2 KPF and #4 SRW. The practice administrator contacted the sales’ staff for each of the 3 “finalist” products, and requested current users of the same specialty for references.

Demonstrations were set-up for the physicians at a regularly-scheduled physician meeting, and the physicians were presented high-level overviews of each software option. The physicians were asked to contact their peers throughout the country in order to survey them on their software solutions, and their satisfaction with their existing systems. The specialty society was surveyed for additional vendor recommendations. All of the input was brought to the practice administrator, who compiled it, and the physicians made a final choice of vendor #4 SRW. Knowing that all three finalists would
meet their needs, SRW was preferred primarily for two reasons. First, the company had prior experience with physicians of the same specialty. Second, the workflow for documenting a specialty visit in the existing EHR record was more intuitive. The physicians wanted easy-to-use templates for documenting patient visits and surgeries that didn’t require multiple clicks and drop downs to select data to populate the form. Also, the physicians wanted to have the ability to type in an open-ended box, and to upload pictures. For the physicians, SRW was the best system for their ease of documentation. This decision was made in the first week of February 2013 (Figure 1).

At this point, the product was now selected, with acceptable features, and within the budget originally outlined. Through regular meetings and written updates by the practice administrator, the physicians voted unanimously on the final software that was selected, which accomplished the objective of consensus and buy-in by each of the 4 physicians. (The billing company had already agreed to run whatever software the practice decided to implement). The only remaining objective was to implement the PM/EHR for a 4/1/2013 effective date, which was in less than 2 months.

IMPLEMENTATION PLANNING:
Implementing an EHR can take a great deal of time; many larger organizations are not complete even after two years with a full-time dedicated staff. Given the short time frame of 7 weeks to accomplish a go-live of 4/1/2013, the practice administrator created a plan of action, with role assignment for each responsible person/party. The practice administrator was the primary lead for the practice, and worked closely with the external billing manager to lead the implementation. The physicians were apprised of the progress at weekly meetings. The steps of implementation are presented in Attachment A.

Weekly meetings between the practice manager and the billing manager were established to review the steps of the implementation to set-up the new software and claims’ processing electronic connectivity. The billing manager and her department documented slightly over 100 hours of time dedicated to the set-up of the new software and implementation of the practice management system. This time commitment was at no additional expense to the practice, as the outside billing company included this set-up as part of the ongoing billing agreement, which reimbursed at a percentage of the revenue earned.

Major hurdles included:

The decision to go cloud-based streamlined the system requirements immensely. The only set-up requirement was to establish Electronic Data Interchange (EDI) connectivity with each payor through the clearinghouse, and this was established quickly by the billing company. The interface for the EHR was web-based and only required a robust internet connection.
The necessary hardware was purchased and installed by the HIT consultant, under a separate budget for practice assets, including phones.

Setting up Electronic Remittance Advises and Electronic Funds Transfer (EFTs) took a bit more time and not all payors in the market allow electronic payments or payment details. It typically takes 3 – 6 weeks to confirm accounts and approve EFTs. This was successfully accomplished for most of the major payors in the market in the abbreviated timeline, but was not actually completed for all payors, including a local payor and Medicaid, until June. This didn’t impact the overall success of this implementation, but it should still be considered as a significant time outlay to track to completion.

Training was required by the physicians, practice manager and staff and the billing company. The PM/EHR vendor had pre-recorded demos of tasks that could be watched, however, lots of questions arose that required billing staff to create ‘tickets’ in the vendor’s system. These tickets were resolved one at a time by the customer support at the PM/EHR vendor, and took lots of time on the phone or via email to clarify the issues and agree upon a process or solution. The billing company estimates “hundreds” of tickets were created, and while some generated a vendor response of “that’s just the way the system works,” the vendor was very often agreeable to alter the software functionality based on the input of the experienced billing team. In retrospect, the intensity of ongoing training with the billing company and the vendor did not stop for seven months, at which point the system ‘glitches’ were corrected and/or the billing staff understood the correct way to navigate through the software.

For many existing practices, the transition to an EHR is traumatic as it demands change and likely a shift in culture. This was less of a concern in this case as the physicians and staff were starting fresh and had the tremendous opportunity to create their own culture. They were, however, leaving a multi-specialty system and a PM/EHR with which they were familiar. This gave them certain expectations as to how a system should look and operate that were not always realistic for a system designed for small practice. It was important, first, that training was adequate enough to identify reduced capabilities of the software and, second, that communication was clear to ensure that the physicians understood the limitations in the context of resources allocated.

Beyond the selection, the implementation included ongoing support of the HIT consultant at significant additional expense. The HIT Consultant continued on at an hourly fee to purchase, configure and install the necessary hardware. This effort continued after the go-live date, and incurred an additional 115 hours of IT consulting time and expense, plus the cost of the hardware.
The implementation was successful. The first batch of electronic claims was transmitted through SRW on April 9th (Figure 1). The first electronic payment was received April 11th.

At the 6 month post-implementation mark, the system was accomplishing the biggest objective: sending claims and posting payments. About 400 surgical cases were billed, and over $500,000 in payments were posted to the system. While the system did not have great reporting capabilities, the data could be pulled manually to accomplish the practice administrator’s needs. The physicians were all very happy with the EHR.

CONCLUSION & LESSONS LEARNED:
The circumstances of the selection of the practice management and EHR system were close to ideal because the physicians were leaving a large multi-specialty group practice, and starting a private practice from scratch. The physicians had the ability to discuss and agree upon the type of culture they would like to work in and how their PM/HER would impact it. Rather than focusing on change, they were able to concentrate their resources on establishing a new practice. There was no existing system to convert, therefore no transfer of patient data, and the physicians had money in a start-up budget. Further, since the physicians were leaving a multi-specialty group, there was no Accounts Receivable that required follow-up. The only issue was the time crunch caused by the delay in selecting a practice management and EHR system in less than 2 months of opening the doors. These exact circumstances may be difficult to replicate, but lessons learned ought to be useful in any future practice automation decision.

Many lessons were learned. First and foremost, hiring an HIT expert was essential. Second, having some initial planning tools assisted in organizing the entire process. Examples of these planning tools include the upfront and ongoing budget for the system; determining ownership versus leasing of the system before seeking vendors; and, taking the time upfront to create a “yardstick” of essential system requirements before looking at any products. This planning allowed the practice to narrow its focus and rule in or out the multitude of available products.

After the decision was made, project management by the practice administrator as the leader of the implementation endeavor was critical. No one involved had experience in doing this; therefore, no one knew the scope of tasks that would be involved to implement a new PM/EHR from scratch. The list of tasks (Attachment A) will be helpful for any practice contemplating an install of a PM/EHR on a short schedule.

Finally, communication was essential throughout the entire process. Regular meetings with the physicians kept everyone on the same page. Conducting the product demonstrations while together as a group allowed issues to surface for key discussions that helped the group achieve a decision that was right for all involved (not just one
provider). Once the decision on the system was made, having weekly meetings between the practice administrator and the billing manager assured on-time implementation.

It is recommended that future practice administrators, contemplating a practice management or EHR install, use a free or low-cost online staff entry system for tracking their time by project. This allows easy recall of each step of the process, and quantification of expenses by area of emphasis, such as IT support, billing set-up, staff training, etc. Access to this data was essential for the retrospective review of this implementation, and determining quantification of expenses and hours relative to the initial budget.
ATTACHMENT A: Steps for Implementation (with estimate of time to complete)

- Sign paperwork with SRW for physician practice ownership of software account (6 Days)
- Sign billing agreement and HIPAA Business Associate agreement, and add billing company as “administrator” on SRW account (1 Day)
- Customize the SRW software to reflect new billing phone number, practice address, etc. (3 hours)
- Establish user sign-in for all physicians, office staff, and billing company personnel, with access as required by each individual user’s role (4 Days)
- Complete electronic payor/e-claims/ERA set up with SRW clearinghouse (3 weeks)
- Establish billing protocol, such as daily billing procedures for getting charges entered (6 Weeks)
- Sign collection agency agreement and HIPAA Business Associate agreement (2 days)
- Set-up HIPAA-compliant document and e-mail exchange system (1 week)
- Watch online self-guided SRW demos, such as “billing implementation set-up” (ongoing)
- Read and familiarize all team members with the online SRW user manual (ongoing)
- Undergo staff-specific SRW webinar training modules, such as (several hours each):
  - “Billing administration” for practice manager and billing staff
  - Loading modifiers
  - Loading insurance company claims’ addresses
  - Completing the fee schedule as a percentage of Medicare for practice-specific codes
  - Adding provider identification numbers and locations of service
  - Creating and submitting a claim
- Set-up payment “mismatch” by loading expected payment amounts by CPT code by payor. This allows future reporting to identify mis-payments when posting
  - Load customized fee schedules (not a percentage of Medicare) manually, such as Medicaid, Workers’ Comp, and some commercial insurers that use homegrown fee schedules (1 day)
- Complete a Medicare 855 form to update billing address (60 days)
- Update Medicaid electronic data interchange to allow billing company access to the portal (60 days)
- Change/update billing address with commercial payors and Workers’ Compensation companies for paper correspondence (60 days)
- Complete payor online access for billing company log-ins to payor website for eligibility verification, local coverage determination research and claim status look-up (24 hours)