Retrospective Look at Physician Practice Executive’s Role in Transitioning an EMR System

Case Study

Ryan Campbell, FACHE, FACMPE

September 27, 2016

This paper is being submitted in partial fulfillment of the requirements of Fellowship in the American College of Medical Practice Executives.
Retrospective Look at Physician Practice Executive’s Role in Transitioning an EMR System

Physician practices, whether independent or hospital employed, struggle with the ever changing requirements for electronic medical records (EMR) systems. With the onset of Meaningful Use, many practices rushed to buy EMR systems and transition from paper charts to an electronic chart and now found those new systems do not meet the ever changing requirements from the federal government. This paper aims to provide lessons learned from past EMR transitions and will provide thoughtful insight for Practice Administrators as they consider their next steps in the electronic age of medical records and the ever changing regulatory environment.

Electronic Medical Record, Electronic Health Record, and Personal Health Records all have similar goals but offer different functionality. Electronic Medical Records are digital version of a patient chart while an Electronic Health Record is a central patient record involving all physicians or providers in a patient’s care, while a Personal Health Record is a digital health record maintained and updated by the patient. For the purposes of this article we are going to focus on Electronic Medical Records.

According to The National Alliance for Health Information Technology (NAHIT), an electronic medical record is “an electronic record of health-related information on an individual that can be created, gathered, managed, and consulted by authorized clinicians and staff within one health care organization,”¹ What started out with a relatively few options for EMRs, today there are over 7,700 certified EMR systems available in the United States ranging from systems with basic functionality to complete practice management systems including integrated billing functionality. EMRs allow physician and office staff to track data, identify patients quickly who need additional care or testing, monitor patient’s health over a span of time, and improve the overall quality of care in a practice by analyzing data and providing trending results to physicians and staff for quality improvement efforts.

Many believe electronic medical records began in the 1960s with a focus on clinical data management but it wasn’t until 1972 that the Regenstrief Institute developed the first medical record. The initial medical records were expensive and cumbersome making them only attractive to government institutions and research organizations. With the onset of affordable personal

computers in the 1990s, electronic medical records began to take hold in more and more
healthcare institutions around the country. It wasn’t until the first term of President George W.
Bush that a call for a standardized EMR by 2014 was issued and EMRs started to emerge in the
everyday physician’s practice. From 2001 to 2011, EMRs grew by 57% in physician practices.²

Today before an EMR can be considered for use in a physician’s office it must pass the
Certification Commission for Health Information Technology (CCHIT) an independent, not-for-
profit group’s certification test. Approved by the U.S. Department of Health and Human Services
(DHHS) Office of the National Coordinator for Health Information Technology (ONC), the
CCHIT has operated as a technology certification body since 2006 but ceased certification
operations in 2014.³ Today ONC has designated the National Voluntary Laboratory
Accreditation Program (NVLAP) as administered by the National Institute of Standards and
Technology to certify EMR systems. The certification process is a multi-step process as outlined
in the graphic.

Graphic 1⁴

³ www.cchit.org
The Centers for Medicare and Medicaid Services (CMS) designed an incentive program to nudge the adoption of EMRs into private practice through the Meaningful Use (MU) program. The Meaningful Use program was meant to provide cash incentives to providers for adoption and use of electronic records to help defray the cost of the investment in hardware and the technology. CMS developed three stages of the Meaningful Use program and used the carrot and stick approach using incentives in the initial phases of the program then turning to penalties as time passes to encourage adoption. Many states followed suit with Meaningful Use incentives based on participation. Some older providers not willing to make the financial investment instead decided to take the penalties in the later years versus changing over to an EMR. Many of these same providers are beginning to retire early from healthcare rather than continue to take the penalty under Meaningful Use and now are proposed in the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). MACRA is set to combine Meaningful Use, Patient Quality Reporting System (PQRS) and other quality and cost metrics into a single formula that will affect provider payments starting in 2019 based on 2017 reporting years.

Some of the best ways for Practice Administrators to learn is through the trials and failures of others. The following retrospective case studies show two examples of success and failure with the selection and roll out of an EMR system and will offer suggestions to prevent other Practice Administrators from encountering the same troubles.

In the first example a relatively small community hospital planned to transition their physician practices from paper charts to an EMR system and put the Chief Financial Officer in charge of selecting the system along with the Chief Information Officer. The main purpose of installing an EMR was to meet the criteria for the Meaningful Use program and not to aid in the delivery of patient care. Several vendors were brought in to demonstrate the capabilities of their systems and present proposals. After reviewing the proposals, the vendor was chosen and a contract signed. At about the same time Administration changed the reporting structure for the clinic and moved it under a different Vice President (VP) with the goal to transition the practices to the new EMR system. The VP discovered that during the selection phase there was little input provided and a check was not done to ensure compatibility with the current external billing company’s software. Due to the lack of provider engagement during the selection process, the rollout of the new EMR was met with resistance from all the providers and the lack of compatibility check with other software created a substantial growth in accounts receivable days. To overcome these challenges, the VP engaged the providers one on one to listen to their concerns and then working with both internal and external client support personnel, addressed
their concerns with the new EMR. The VP also engaged with the external billing company to evaluate options for interfacing with their software but decided in the end to make a billing company change due to the lack of current technology with the billing company. An after action review found several major flaws in the selection and rollout of the EMR system. First, the providers were not a key member of the selection team and therefore had little buy in when it came time for implementation. Secondly, the EMR system was not checked for compatibility with other systems thus creating confusion and a delayed revenue stream during implementation. Third, the hospital failed to plan for training resources for the practices during implementation.

In the second example an urban hospital undertook transitioning from one EMR system to a separate and different EMR system to increase efficiency and improve the patient care experience. Due to the need to expand the capabilities of their current system, the hospital began evaluating systems that could meet their needs today but also allow for growth for future needs. The hospital brought together a cross section of physicians, administrators, and IT personnel to form a review committee to meet with the vendors and evaluate the systems. After reviewing all the top vendors on the market, the committee made the decision to pilot one of their top choices in two practices and allow time to further evaluate the product. During the trial period, administration along with IT negotiated the final purchase price to include training hours and onsite tech support during full implementation. After the trial period, the final system was selected and rolled out to the various clinics in a step-by-step process that allowed for easy implementation. The physicians who pilot ed the system were able to serve as mentors to the newly implemented physician practices and offer tips and tricks to make implementation a smooth transition.

For Practice Administrators contemplating adding a new EMR system or transitioning from one system to another, there are valuable lessons to be learned from the two previous scenarios. First, provider engagement at the outset is important to any successful project. By having providers onboard and engaged, it allows you, the Practice Administrator, to ensure the goals are aligned from the outset. Secondly, beginning with the end in mind is always a vital key to success. The MGMA Book of Knowledge (BOK) encourages all Practice Administrators to ensure their governance structure has identified the end goal as well as key aspects of the project before it begins. This allows the Practice Administrator a roadmap to ensure they are meeting the objectives as the project progresses. In the examples provided, the first hospital was selecting an EMR to check the box and not improve or enhance patient care. In the second example the hospital’s main goal of transitioning EMRs was to improve efficiency and enhance patient care.
through technology. Knowing the reason for selecting or transitioning EMRs will aid the Practice Administrator when evaluating the various systems available. The third lesson is valuable for Practice Administrators is to never underestimate the need for training resources and external resources for staff. The fourth lesson to be learned, is to have a keen understanding of the impact the new EMR will have on your practice by asking a few simple questions. Will it make documentation by the provider or clinical staff easier or harder? Will it make obtaining and processing patient information more difficult or simpler for staff and patients? What impact will the new system have on processing financial records? Are there external training experts that need to be brought in to help ensure user success? By asking these simple questions upfront, Practice Administrators and their governance structure can assure a better chance of success for the practice during an implementation.

Another important piece of any EMR implementation is to understand the financial impact the new system will have on the practice. Practice administrators should begin with simple questions before developing their cost estimate as part of the selection process. What is the total cost of the system? What are the renewal costs each year? Is there additional costs associated with implementation such as tech support or onsite training? What additional reimbursement can we expect based on potentially better documenting the care provided to patients? How will this affect processing time for claims? By asking these questions Practice Administrators can better estimate the costs and provide this information to their governance structure as part of the due diligence process. Failing to understand the financial impact can be a worst case nightmare during implementation.

The final piece to a new EMR system is setting realistic expectations both with governance structure and with front line staff prior to implementation. If we begin with the end in mind as the BOK suggests, communicating this vision to staff is the first key step in a successful rollout. If they understand the end goals, most of the time staff will help management and the providers achieve this vision. In the first example in this article, the hospital failed to set expectations with providers or staff and the result was a problem filled rollout since no one knew the end goal. In the second example, providers were not only included in the decision making process, they became champions to their peers during the rollout which is what each Practice Administrator should strive for.

The intent of this manuscript was to provide Practice Administrators with insight and lessons learned from two very different EMR implementation projects. These examples aid
Practice Administrators in their decision making when it comes to selection of future EMR systems in their practice. By learning from these lessons, Practice Administrators can avoid costly mistakes and make smart decisions selecting an EMR.