## 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**

<table>
<thead>
<tr>
<th>Factor</th>
<th>Percentage</th>
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<tbody>
<tr>
<td>Funding</td>
<td>24%</td>
</tr>
<tr>
<td>Anticipation of Difficulty</td>
<td>31%</td>
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<tr>
<td>Process Flow Redesign</td>
<td>19%</td>
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<tr>
<td>Compatibility with Existing Systems</td>
<td>20%</td>
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<tr>
<td>Lack of Support by Medical Staff</td>
<td>10%</td>
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*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


- 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

**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 bottleneck 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**