7 Steps to a Successful EMR Deployment

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Agenda

- The Promise of Health Information Technology
- HIT - State of the Union
- 7 Steps to a Successful HIT Project

The Promise of HIT

- **HIT is primarily about improving QUALITY**
  - **Clinical Care & Outcomes**
  - **Patient Engagement in Care**
  - **Communication with Patients and Between Providers**
  - **Customer Service**
  - **Efficiency**
  - **Decreased Waste, Error, & Unnecessary Redundancy**
- **Some secondary goals:**
  - **Improved Coding**
  - **Improved Patient Satisfaction**
  - **Improved Revenue**
  - **Reduced Cost**

HIT - State of the Union

- EMRs are ready for “prime time” but only 6.3% of doctors have implemented “fully functional” electronic medical records systems
- Government is encouraging physicians to adopt EMR technology by offering financial incentives in ARRA stimulus legislation
- The infrastructure (Health Information Exchanges) for widespread and secure exchange of information is not yet in place

Factors in HIT Trepidation Among Physicians

- Uncertainty resulting from the bad economy and decreasing reimbursements
- Fear caused by "horror stories" of failed implementations
- Confusion about Meaningful Use rules and certification
- Distraction by RAC, PECOS, HIPAA, etc.
- Doubt fuelled by outrageous statements from vendors, insurers, politicians, etc.
- Reluctance to face the pain of CHANGE
- Avoidance of disruption to the practice
- Disinclination to absorb the decrease in productivity and resulting loss of revenue

Characteristics of a Successful HIT Project

- Follow a Proven Process – 7 Steps
- Cultivate Universal Buy-In and Commitment
- Plan to overcome weaknesses and cure inefficiencies
- Don't Go it Alone!
  - ONC Extension Centers
  - HIT Gurus
  - Implementation Experts

Step #1: Develop HIT Strategy

- **Set Goals & Expectations**
  - Quality
  - Efficiency
  - Revenue
- **Make Key Decisions**
- **Budget**
- **Define the Time-Line**
- **What Could Go Wrong?**

Plan to Optimize Goals & Minimize Problems

Step #2: Practice Assessment

- **Document Current Work-Flows**
  - Identify Weaknesses
  - Predict EMR's Impact
- **Measure Provider Productivity**
  - Determine Baseline for Post Implementation Comparison
- **Ascertain Opportunities for Improvement**
  - Revenue Cycle Performance
  - Operational Efficiencies

How well does your practice cope with change?

Step #3: Optimize Revenue

- **Ancillaries**
- **Augment Patient Volume via Personal Health Record with Secure Patient Portal**
  - Convert Phone Medicine to "E-Visits"
  - Convert Un-Billable Forms Work to "PHR Medical Records Fee"
  - Deliver Wellness Programs
- **Quality Incentives**
  - PQRI, E-Prescribing
  - CMS Incentive for EMR Adoption
  - Patient Centered Medical Home
- **Improve Revenue Cycle Performance**

Augment Patient Volume

Practice Statistics / Metrics		Quality Improvement		Revenue Enhancement		
# of visits per physician per day	24			**Total Revenue Enhancement per month**		**Annualized**
# of "phone encounters" per physician per day	12	Conversion of phone medicine to e-visits	50%	e-Visit Revenue $15 per	$1,800	**$21,600**
# non-billable forms (i.e. disability, handicapped parking, clearance for school/work, etc.) filled out per physician per day	6	Attach forms to patient's Personal Health Record	50%	Additional medical records revenue $10 per	$600	**$7,200**
# of patients signed up for Wellness Program, i.e. diabetes, post-op, cardiac, weight loss, etc.	50	Engage patients in care through: Self-Assessments Patient Education Coaching Progress Tracking		"Program Fee" $25 per month per patient	$1,250	**$15,000**
% of BCBSM patients (practice designated as "Patient Centered Medical Home")	25%	Care Coordination Evidence Based Medicine "Health Watch"		10% reimbursement increase from BCBSM	$720	**$8,640**
Office days per month	20			**Totals**	**$4,370**	**$52,440**

Improve Reimbursement & Collection Performance

Improvement Initiative	Driver
Negotiate Favorable Reimbursement Rates	Business Analytics
Prevent Eligibility Denials	Batch Eligibility Application
Prevent Claim Errors	Claim Editing System
Prevent Coding Errors	Coding Assistance Module
Manage Under-Payments	Contract Management System
Convert Denials to Payments	Denial Management System
PATOS - Payment At Time OF Service	Business Analytics
Increase Self-Pay Payments	Patient Portal
Secure High-Deductible Accounts w/ Credit Card	EDI Clearinghouse

Use Technology to Drive Revenue Cycle Improvement

Step #4: Select the "Best Fit" EMR System

- **One Size Does Not Fit All**
- **Physician adapts to EMR**

  Or
- **EMR adapts to physician practice patterns**
- **System Integration**
  - Single Database
  - Interfaces to PM System
- **Server on-site? Hosted? ASP?**
- **Use Weighted Decision Matrix to Find the EMR Best Suited to Your Practice**

What is Important to You?

Weighted Decision Matrix

Weight		1	2	3	4
	Grand Totals	831	870	769	884
	Cost				
	Product Demonstrati on Scores	283	364	293	371
	References	113	92	83	102
	Overall KLAS Score	71	86	77	94
	Total Matrix Score	364	328	316	317
	Electronic Medical Record				
3	User Friendliness	54	57	57	54
3	Training & Implementati on	15	12	12	15
3	Support	15	15	15	12
2	Input Methodology	16	16	14	16
2	Document Imaging & Indexing	12	12	12	12
3	Template Design	33	24	24	30
2	Integrati on	24	18	20	24
3	Clinical Rules	27	18	18	18
2	Coding Assistance	4	2	4	0
3	Reporti ng	54	54	42	42
3	Medicati on Module	54	42	48	42
1	Messaging	6	6	6	6
2	Technical Considerati ons	8	8	8	8

Step #5 Technology Assessment

Assessment Process

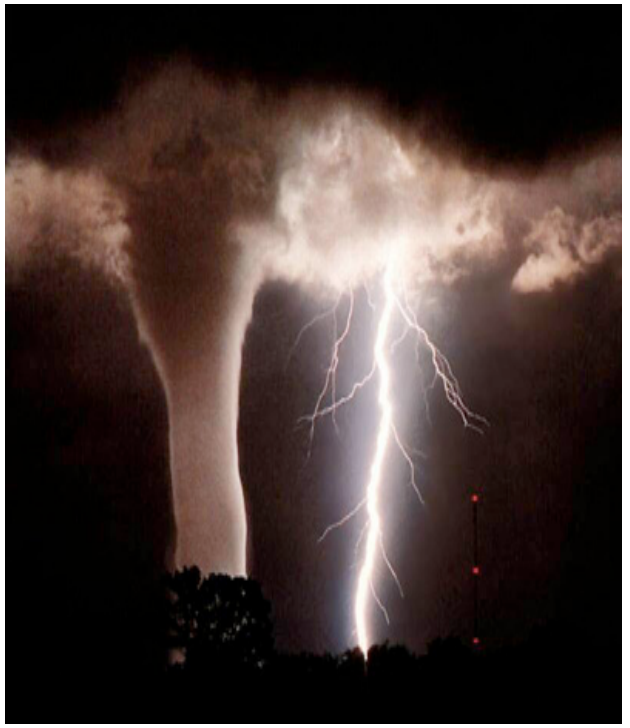
- **Gather Data**
  - Local –Area Network (LAN)
  - Server Environment
  - Wide-Area Network (WAN) / Remote Access Methods
  - Security Posture
- **Analyze Data**
  - Discovery data of current environment
  - Medical industry best practices
  - Operational goals
  - Feasibility
- **Prescribe Solutions**
  - It's about the business not technology
  - Phased, gradual approach to change
  - Process, Process, Process

Key Lessons Learned

- Don't assume anything
- Technology and IT support are critical factors to success
  - Infrastructure can = 30-50% total EMR costs
- PM/EMR vendors specify "minimum requirements" in proposals
- Independent IT assessment imperative
  - Choose vendor with relevant HIT experience
- Rollout schedule to be fluid.
  - Push schedule back if necessary!
- IT staffing & post EMR requires diversified staffing
  - Consider augmenting internal efforts

Step #6: Effective Implementation

- Implementing EMR turns practice upside down
- Weaknesses will be magnified
- The vendor's implementation team is seldom enough
- Most practices need a consultant to augment the implementation team & hold the vendor accountable



Critical Factors for Successful Implementation

- Document current work-flows
- Project plan addresses weaknesses
- Universal buy-in
- Commitment to training
- Hold the vendor accountable
- Be careful what gets pre-loaded
- Cut providers' schedules temporarily
- Massive resources at go-live
- Circle back after initial learning curve

Step #7: Demonstrate Meaningful Use

- **Medicare Incentive is a 75% Bonus**
  - Based on Physician's Annual Medicare Payments
  - Capped at Yearly Maximum Amounts (see below)

	Medicare Incenti ve paid each year						
Year the practi ce qualifi es EMR "meaningful use"	2011	2012	2013	2014	2015	2016	Total Incenti ve Paid
2011*	$ 18,000	$ 12,000	$ 8,000	$ 4,000	$ 2,000	$ -	$ 44,000
2012		$ 18,000	$ 12,000	$ 8,000	$ 4,000	$ 2,000	$ 44,000
2013			$ 15,000	$ 12,000	$ 8,000	$ 4,000	$ 39,000
2014				$ 12,000	$ 8,000	$ 4,000	$ 24,000
2015**					$ -	$ -	$ -

* Or before

** Medicare Payment Reducti ons Begin if EMR Not Adopted

Some Practices Don't Have Enough Medicare

- **Medicaid Incentive Based on Cost**
  - **First Year – 85% of EMR Initial Cost, Up To $25,000 (Max. Incentive = $21,250)**

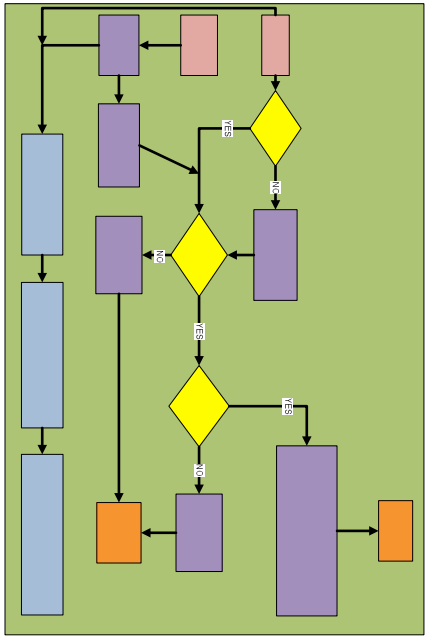
- **5 Subsequent Years – 85% of EMR Annual Cost, Up To $10,000 (Max. Incentive = $8,500)**
  - **Medicaid Must be At Least 30% of Charge Mix**
  - **Pediatricians need 20% Medicaid, but receive 66% of incentive payments**

Final MU Criteria published 7/13/2010

2011 Meaningful Use Criteria			
"Core" Set		"Menu" Set	
Use CPOE	Drug-drug, drug-allergy checks	Lists of patients w/ specific conditions	Send patient reminders for preventive/follow-up care
Medication list	Medication allergy list	Drug - formulary checks	Lab results as "structured data"
Provide patients with electronic copy of their health information	Record smoking status	Provide patient-specific health education resources	
Report ambulatory quality measures	Capability to exchange clinical information with other providers	Capability to submit immunization records to registries	
ICD-9 problem list	E-Prescribing	Provide patients with timely electronic access to their health information	
Demographics incl. race/ethnicity	Record vital signs & calculate BMI	Provide summary care record at transition of care or referral	
Implement 1 clinical decision support rule	Provide clinical summaries for each office visit	Capability to provide electronic syndromic surveillance data to public health agencies	
Protect electronic health information through appropriate technical capabilities		Perform medication reconciliation at encounters and transitions of care	

Changing Clinical Work-Flows

- All certified EMRs will have functionality to support Meaningful Use
- Hard part will be in the work-flows that Meaningful Use requires
- It won't be easy
  - Significant time and effort!
- Worth the effort beyond the ARRA financial incentives
- Analyze criteria
  - Then design and implement new work-flow



Key: Re-analyze , re-design , re-implement until the system performs & goals are met

Final Recommendations

- **Accept HIT as inevitable**
  - But extent will differ from practice to practice
  - "Doing Nothing" is an option, but….
  - Patients will demand it (recall online banking and ATM)
- **Discuss HIT with EVERYONE**
  - Within the practice
  - Outside the Practice
  - Hospitals
  - Payers
  - Potential Partners
- **Determine a Strategy/Plan/Process**
  - Execute 7 Steps