

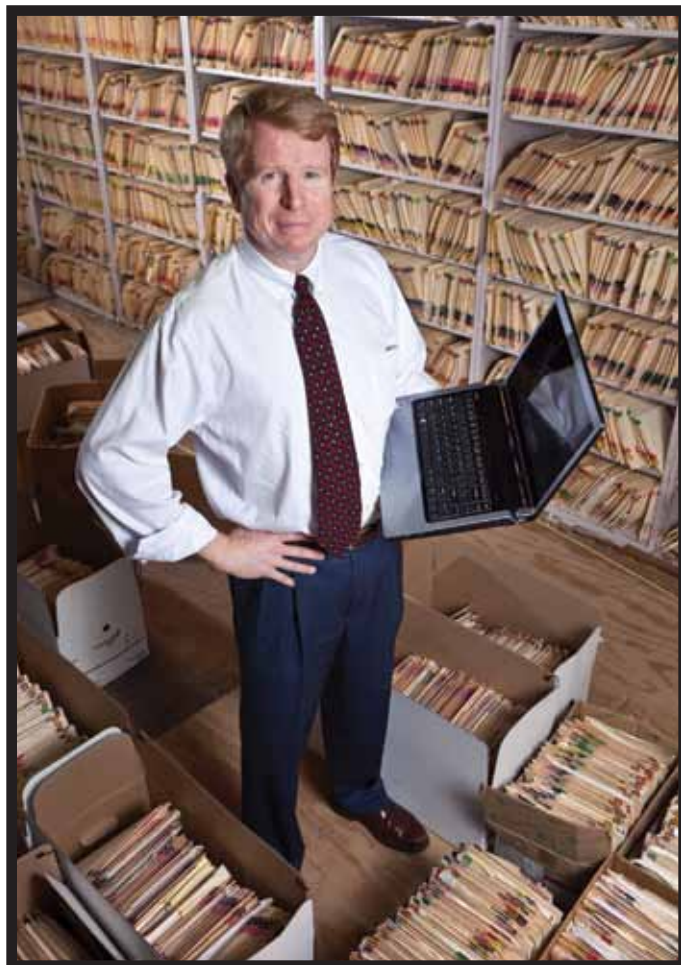
# Measure twice, cut once

Be careful choosing an EMR

**BY CRYSTAL CONDE** The way one high-tech expert sees it, converting a medical practice from paper medical records to an electronic medical record (EMR) system is like building a house. It requires adequate research, preparation, time, patience, money, monitoring, and follow-through.

“When I hear horror stories of botched EMR implementations, they typically involve a practice that hired an EMR vendor that didn’t finish the job or a practice that didn’t prepare properly,” said John Lubrano, PhD, president of Austin-based Protis IT Solutions. “Just like when building a house, when employing an EMR, physicians need to develop a plan for implementation and check in regularly with the vendor. The more a physician is on site and involved, the greater the chances of successful EMR execution.”

Dr. Lubrano specializes in office automation and EMRs for medical practices and has been Texas Medical Association Practice Consulting’s technology expert since 2004. As part of his consulting services, Dr. Lubrano guides physicians through choosing an EMR system to meet their practice’s needs, developing a reasonable implementation plan, and making necessary infrastructure changes to accommodate the new system. He also provides ongoing support of



Austin colorectal surgeon David Fleeger, MD, recommends physicians choose an EMR system that fits well with their office workflow and is easy for the office personnel to use. He implemented an EMR system in his multisite practice last January. He had to alter his work routine to accommodate its capabilities.

the network and continued assistance to keep the implementation plan on track.

He says physicians need to exercise due diligence in selecting EMR products by witnessing them in action.

“Once physicians narrow down their product options, they should talk to colleagues in their specialties who use the systems and schedule a site visit to get an idea of their ease of documentation,” he said.

David Fleeger, MD, an Austin colorectal surgeon and member of TMA’s Council on Practice Management Services, knows how important it is to choose an EMR product that’s compatible with the medical practice. It took his multisite practice six months to develop an EMR system, which he implemented in January.

During the process, Dr. Fleeger learned that although the EMR system attempts to fit into the practice’s workflow, it doesn’t perfectly correspond. He had to alter his work routine to accommodate the

system’s capabilities. He changed his workflow to allot additional time mid-morning and in the afternoon each day to catch up with documentation of medical records.

“From a physician’s standpoint, workflow becomes a major issue,” he said. “That’s a little painful because you’ve been

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doing your patient evaluation and documentation the same for years. Now you have to find a new way to do it that fits with the EMR system.”

He says the journey to EMR implementation isn't easy.

“Overall, I'd say the conversion process was, at times, painful but tolerable,” Dr. Fleeger said.

Dr. Fleeger encourages physicians considering switching to an EMR system to visit the TMA website, [www.texmed.org/hit](http://www.texmed.org/hit), for articles, white papers, case studies, tips, and other resources on adopting health information technology (HIT). (See “TMA HIT Resources Aid Physicians,” opposite page.)

He also stresses the importance of soliciting input from all physicians and staff members who will be using the EMR system.

“You should choose an EMR system that fits well with your office's workflow and is easy for your front-desk and back-office personnel to use,” he said.

## **Making the transition**

Dr. Fleeger says the financial incentives in the Health Information Technology for Economic and Clinical Health (HITECH) Act for physicians who use EMRs helped persuade him to make the change.

He isn't alone. Fifty-nine percent of the respondents to last year's TMA EMR Survey indicated they would attempt to qualify for the stimulus funds. The sur-

vey measured physicians' use of office technologies such as EMRs, e-prescribing, and health information exchanges.

Forty-three percent of the physicians reported using an EMR, up from 33 percent in 2007 and 27 percent in 2005. The percentage of physicians with no plans to implement an EMR system decreased from 25 percent in 2007 to 16 percent in 2009.

Dr. Fleeger says the \$19 billion in funding in President Obama's economic stimulus package to help physicians purchase and implement HIT systems signals the inevitable conversion of the entire health care system to EMRs.

Under the HITECH Act, physicians will not receive payments up front but will be eligible for funds from 2011 through 2016 if they demonstrate “meaningful use” of a certified EMR technology.

Non-hospital-based physicians who accept Medicare patients could earn up to \$44,000 in incentives in those five years. For those who meet the requirements by 2011 or 2012, the first Medicare incentive payment is \$18,000. The incentives then drop to \$15,000 by 2013 and \$12,000 by 2014. (See “Physician Medicare Incentive Payments, by Year of Eligibility,” page 36.)

In addition, non-hospital-based eligible physicians with at least 30 percent Medicaid patients could receive up to \$63,750 over six years, beginning in

2011 (\$21,250 for year one and \$8,500 for each of the next five years).

The government offers incentive payments to physicians who meaningfully use EMRs to offset costs associated with implementation, which can be a barrier to adoption.

According to the second edition of TMA's *Electronic Medical Record Implementation Guide: The Link to a Better Future*, total startup costs range from \$11,600 to \$31,744. This includes software licenses, vendor implementation and training, e-prescribing, practice management, technical support, other fees, and hardware. Other associated costs, such as data conversion, eligibility verification, secure messaging, reporting tools, and voice recognition software, can run from \$6,000 to more than \$10,000. A price and product comparison of the most commonly used EMR systems in Texas is available at [www.texmed.org/emrtool](http://www.texmed.org/emrtool).

The implementation guide and EMR survey results are available on the TMA website at [www.texmed.org/hit](http://www.texmed.org/hit).

In addition, Dr. Fleeger says his transition to an EMR system coincided with merging five individual colon and rectal specialty practices and six physicians into one medical group.

“Because we were combining several practices and office locations, we all decided it would be more efficient in the long run to have an EMR system in place. Putting all that patient data into an EMR system makes it easier to access patient charts from different locations,” he said.

Dr. Fleeger also decided to switch to an EMR system because he thinks it will help him monitor the accuracy of his billing and coding and avoid scrutiny from the Centers for Medicare & Medicaid Services recovery audit contractor program.

## **Strategy key to conversion**

When it comes to converting from paper to electronic records, there are no hard-and-fast guidelines or protocols. Physicians can opt to scan paper records and incorporate them into the EMR; draft a summary of the patient's visits and care before implementing the EMR; or simply

note the date of conversion from paper to electronic records and maintain the paper records as reference.

Jane Holeman, vice president of risk management for the Texas Medical Liability Trust (TMLT), says TMLT generally instructs physicians to preserve the integrity of the paper records until they are comfortable with the EMR, as well as the skill level of the users.

“For those who decide to scan the prior records and incorporate them into the EMR, I would recommend that the paper records be maintained for a period of time to allow for adjustment to the EMR and also to ensure the security and integrity of the system,” Ms. Holeman said.

Dr. Lubrano says the conversion method used is up to the physician.

“The only advice that we generally give physicians is, if they decide to scan paper records and incorporate them into the EMR, enter any patient records on a per-visit basis. It’s not a worthwhile expense to do all of the hundreds or thousands of patient charts at once,” he said.

Additionally, physicians need to adhere to Texas Medical Board rules regarding maintenance of medical records, regardless of whether paper or electronic. To view Section 165.1-165.6 of the board rules, visit [www.tmb.state.tx.us/rules/rules/bdrules\\_toc.php](http://www.tmb.state.tx.us/rules/rules/bdrules_toc.php).

Before EMR implementation, Dr. Lubrano advises physicians to conduct a practice assessment and workflow analysis. TMA Practice Consulting can help physicians prepare for an EMR system by providing those services. (See “TMA HIT Resources Aid Physicians.”)

“Don’t change your processes on the fly while switching to an EMR,” he said. “Do a thorough evaluation of your practice and processes and decide how they’re going to change.”

He also recommends physicians make the change as quickly as possible but in fixed stages to avoid becoming overwhelmed and discouraged. For example, he says it’s usually best for a practice first to tackle practice management software functions, such as billing, scheduling, coding, and collections.

“A practice can get practice management functions automated first and then work on developing the infrastructure

within the EMR, such as workflow and templates,” he said.

Customizing the EMR to fit a practice’s needs is time-consuming. Dr. Lubrano says physicians and staff members should consult patient charts to figure out the common CPT codes used.

Dr. Fleeger says his greatest frustration with implementing an EMR was the need to create templates to meet the needs of his subspecialty.

“When you purchase the EMR product, you contract for so much time for the vendor to develop your templates. Inevitably, the amount of time you’ve purchased isn’t enough,” he said. “You can’t have one template for all doctors, so that means you have to take time to customize templates to include all the common billing codes for your subspecialty or relevant family history questions, for example.”

Dr. Lubrano recommends physicians choose an EMR product certified by the Certification Commission for Health

Information Technology (CCHIT). The CCHIT Certified® program is an independently developed certification that includes a rigorous inspection of an EMR’s integrated functionality, interoperability, and security using criteria developed by CCHIT’s expert work groups. To review CCHIT-certified products, log on to [www.cchit.org/products](http://www.cchit.org/products).

It’s also a good idea, according to Dr. Lubrano, for a practice to designate an EMR liaison to be the ongoing project manager who learns the ins and outs of the new system.

“Typically, the physicians choose a technology-savvy employee to take the lead. When staff members and physicians have questions about the EMR, they can go to the designated point person in the practice,” he said.

While implementing the EMR system, Dr. Lubrano says physicians would be wise to anticipate a decrease in productivity initially.

“Dial back your schedule a little when

## TMA HIT resources aid physicians

**For tools to help** physicians assess whether their practices are ready to adopt an electronic medical record (EMR) system and for information about health information technology (HIT), log on to the HIT page on the TMA website, [www.texmed.org/hit](http://www.texmed.org/hit).

Resources include TMA’s *Electronic Medical Record Implementation Guide: The Link to a Better Future*, which offers up to 3 hours of continuing medical education credit, and TMA’s EMR Readiness Assessment Questionnaire and white paper. Additional materials include HIT-related articles and case studies that offer firsthand physician accounts of implementing an EMR.

The HIT Department also offers an EMR comparison tool to aid physicians in shopping for an EMR system. Log on to [www.texmed.org/emrtool](http://www.texmed.org/emrtool).

For more information, contact TMA’s HIT Help Line at (800) 880-5720, or e-mail [HIT@texmed.org](mailto:HIT@texmed.org).

In addition, TMA Practice Consulting can provide doctors with a practice assessment and workflow analysis to start them on the path to adopting and implementing an EMR system. Information is available by calling (800) 523-8776 or e-mailing [practice.consulting@texmed.org](mailto:practice.consulting@texmed.org).

## Physician Medicare incentive payments, by year of eligibility

2011	\$18,000			
2012	\$12,000	\$18,000		
2013	\$8,000	\$12,000	\$15,000	
2014	\$4,000	\$8,000	\$12,000	\$12,000
2015	\$2,000	\$4,000	\$8,000	\$8,000
2016	—	\$2,000	\$4,000	\$4,000
<b>Total</b>	<b>\$44,000</b>	<b>\$44,000</b>	<b>\$39,000</b>	<b>\$24,000</b>

Note: Eligible physicians practicing in a health professional shortage area are eligible for a 10-percent increase in incentives.

Source: U.S. Department of Health and Human Services Office of the National Coordinator for Health Information Technology.

you are converting to the EMR in those first few weeks. This will give everyone time to get up to speed on using the EMR," Dr. Lubrano said.

Dr. Fleeger cut back his patient volume during the first month of EMR implementation. Instead of seeing 20 patients a day, he was seeing 12 to 15. He hired a temporary employee to scan charts into the EMR system. From January to July, 3,000 patient charts had been scanned.

Because the process of EMR implementation is such a large undertaking, Dr. Fleeger encourages physicians to be patient.

"I've gained a few gray hairs with this, but I think that's just part of the process. We all have to learn to accept change," he said.

## Physicians guide RECs

**Texas Medical Association** member physicians play an important role in the newly formed regional extension centers

(RECs) created as part of the Obama administration's 2009 economic stimulus bill. The RECs give physicians education and technical assistance to "meaningfully use" certified electronic medical record (EMR) technology.

Physicians participating in the Medicare and Medicaid programs are eligible for incentives if they achieve meaningful use. For Medicare, the incentive cap is \$44,000 over five years and, for Medicaid, it is up to \$63,750 over six years.

Texas will be home to four RECs:

- North Texas Regional Extension Center, anchored by the Dallas-Fort Worth Hospital Council;
- Gulf Coast Regional Extension Center, led by The University of Texas Health Science Center at Houston;
- CentrEast Regional Extension Center, directed by Texas A&M Health Science Center Rural and Community Health Institute; and
- West Texas Regional Extension Center, headed by Texas Tech University Health Sciences Center.

The federal government subsidizes RECs' consulting services, which will

focus largely on getting physicians to achieve "meaningful use" of EMRs. All four Texas RECs charge an annual subscription fee of \$300 for their services.

Types of services offered by most of the RECs include:

- Workflow analysis and practice redesign,
- EMR vendor selection,
- Education, and
- "Meaningful use" achievement.

TMA worked hard to make sure physicians hold half of the seats on the REC governing boards. "The implementation of the HITECH initiative could have profound effects on physician practices, and we need to have a strong voice at the table," said Sidney Ontai, MD, MBA, of Plainview, a member of the West Texas REC. He also is the immediate past chair of TMA's Council on Practice Management Services and a member of TMA's Ad Hoc Committee on Health Information Technology (HIT).

TMA physicians on the REC boards include:

### North Texas Regional Extension Center

Fort Worth

Matt Murray, MD

Pediatric emergency medicine

Dallas

David Bragg, MD

Family practice

Tyler

Ken Haygood, MD

Family practice

### Gulf Coast Regional Extension Center

(two-year appointments)

Houston

Lewis Foxhall, MD

Family practice

Beaumont

Gary Mennie, MD

Obstetrics-gynecology

San Antonio

Dianna Burns-Banks, MD

Pediatrics

Corpus Christi  
Ernest Buck, MD  
Pediatrics

Edinburg  
Martin Garza, MD  
Family practice

Houston  
Charles Stiernberg, MD, MBA  
Otolaryngology

**CentrEast Regional Extension Center**  
(one-year appointments)  
Austin  
C. Mark Chassay, MD  
Family practice, sports medicine

Waco  
Timothy Barker, MD  
Family practice

San Marcos  
Lenore DePagter, DO  
Internal medicine

Nacogdoches  
George Hugman III, MD  
Family practice

**West Texas Regional Extension Center**  
Plainview  
Sidney Ontai, MD, MBA  
Family practice

Lubbock  
Robert Posteraro, MD  
Radiology

El Paso  
Robert Emmick, MD  
Emergency medicine

Abilene  
Dean Schultz Jr., MD  
Family practice

TMA will support the RECs in educating physicians about and enrolling them into the program. For more information, log on to TMA's Regional Extension Center webpage, [www.texmed.org/hit](http://www.texmed.org/hit). Also, read the April 2010 *Texas Medicine* article "RECs to the Rescue: Regional Centers Help Physicians Use HIT."



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## Satisfied patients benefit bottom line

**Some medical practices** dismiss courtesy training as “touchy-feely stuff” with no direct impact on the bottom line. Staff members who treat patients with consideration, however, help their employers and colleagues work more efficiently.

In addition, practices with staff members who don’t watch their manners often watch patients walking out the door instead. Worse, patients who feel they’ve been treated poorly as customers are more likely to bad-mouth your practice to their friends and family, file formal complaints, or even sue.

But even the best practices have to deal with patient complaints. Adopting a formal patient complaint procedure for your practice provides a great training guide and orientation for new employees as well as a reference for current staff.

Include the following guidelines in your policy:

- Listen to the patient without interrupting him or her;
- Clarify the problem and the patient’s needs or wants;
- Notify the physician and/or practice manager of the complaint;
- Respond to the complaint in a timely manner;
- Give the patient the practice manager’s name and telephone number;
- Document the patient’s complaint, if indicated, including the people notified and the resolution; and
- Follow up with the patient to verify the resolution of the problem.

For tips on how to put these guidelines into practice, read “How to Handle Patient Confrontations” on the Texas Medical Association website, [www.texmed.org](http://www.texmed.org). From the home page, select Practice Management from the menu, and click on E-Tips. ■

Crystal Conde is associate editor of *Texas Medicine*. You can reach her by telephone at (800) 880-1300, ext. 1385, or (512) 370-1385; by fax at (512) 370-1629; or by e-mail at [crystal.conde@texmed.org](mailto:crystal.conde@texmed.org).