Agenda

1. Introductions
2. Financial Risks of EHR / PM Implementation
3. EHR Implementation Case Studies
   - New Implementation
   - System Conversion
4. ROI: Clinical Quality and Financial Results
5. Questions
Implementation Risks

2 Major Risk Categories

1. Change Management: Can be mitigated over time
   • Short term adoption & acceptance challenges
   • Inefficiencies

2. Financial: Can bankrupt a practice
   • Reduced physician productivity
     ➢ Also impacts patient access & patient experience
   • Negative impact on revenue cycle performance

This presentation focuses primarily on Financial Risks, however the tools discussed also reduce Change Management challenges
1. The medical group consists of 250 physicians and 32 practice locations across 3 states.

2. Primary care and specialty practices were acquired by a large health system to form their ambulatory network, however they maintained many characteristics of a private practice from an operations perspective:
   - Physicians compensated based purely on productivity.

**EHR Project Background: The early years**
- 4 practices, 8 physicians in total, implemented in first two years
- New CIO and new EHR Project Director:
  - Redesigned governance to streamline decision making
  - Adoption of Cumulative Learning Implementation Methodology
  - Implementation “Guiding Principles” published
- 30 practices implemented over next two years
  - Within defined time period, 250 physicians all maintained or exceeded previous productivity standards.
New Implementation Goal 1: Physician Adoption

Strategies Deployed

Pre-Implementation Activities
- PREPARE physicians and clinical staff for learning: Communication
- EQUIP users with the right tools: Education
  - Online training
  - Limited Medical Record Abstraction as re-enforcement

Implementation Activities
- GUIDE users at crucial times
  - Training and Go-live are synchronized
  - Use of physician preceptor at go-live
  - Onsite go-live support for 3 week implementation plus 2 weeks post go-live

Post Implementation
- OPTIMIZE workflows and system functionality for maximum efficiency
1. Orientation visit 3 months before go-live
   - What to expect
   - Establish roles (MD and RN super users)
   - Establish timelines for training and go-live (remember to identify vacations)
   - Abstraction strategy policy discussion
   - Prepare charts: Facesheets
     - Problem List
     - Medications
     - Allergies
     - Immunizations (if not populated from PM system)
     - Growth chart
   - Discussion of schedule reduction
   - IT infrastructure walk through (networking, workstations and printers, mounting brackets, electrical outlets, cabinet modifications etc)
   - Observe and document current state workflows (How and Why)
2. Limited Medical Record Abstraction by Physicians and Clinical Staff

Timeline: 60 days before go-live

Benefits:
- It’s all about LEARNING, not about giving the staff extra work to abstract all charts
- Using LIVE patients, but not in front of the patient - relevant learning examples
- Online tutorials and/or basic training on abstraction fundamentals
- Reduces anxiety at go-live by familiarizing physician with the system and navigation
- No blank chart at go-live

Goal: 30 records per provider (1 chart (5 minutes) every other day)

Additional Considerations:
- Implementation Coordinator monitors daily progress through reporting to identify at risk providers (quality and or volume) and provides necessary remediation
- Develop policy for use of abstractionists and scanning to fully populate charts
3. **Define Workflows:** The implementation involves much more than a computer

**Timeline:** 30 days before go-live

- Leverage best practices whenever possible, but acknowledge what works well at the practice level and why
- Keep what works!
  - Standardization for the sake of standardization alone will only increase change management and adoption challenges
- Use Nurses and Medical Assistants to analyze gaps between current state and ProHealth best practice to finalize future state
Implementation Tasks: Training Approach

Key Principles of Training in the Cumulative Learning Methodology:

• Teach INCREMENTALLY to maximize learning and confidence
  • Break education into bite size nuggets

• Deliver training at the local level (not just application, but also workflows!)

• Reinforce training with limited abstraction

• Consider role of Physician Champions as Preceptor at go-live:
  “Physicians feel most comfortable learning from other physicians”
  • Preceptor model dates back to medical school
  • Physician teachers are deemed more credible
  • Access to the “forbidden” exam room at go-live
  • More relevant and rapid learning curve
Implementation Tasks: Go-Live Support

- On-site Go-Live support continued for 2 weeks (3 weeks of training + 2 weeks of post go-live support = 5 week training and support timeline)

- Week 6: Transition from Implementation Mode to Maintenance Mode
  - Don’t abandon users, have formal transition process
  - Implementation Team went onto next practice rollout
  - Maintenance Team supported practices that were live
Optimization Tasks: Maximize Efficiency

- Formal circle back process at published timeframes:
  - 30, 90 & 180 days after transition to Maintenance Mode
- Recognize that most users will NOT learn or remember everything you teach them
- Assessment of what they are doing right, identification of opportunities for improvement (workflow and application)
- Directed and documented instructions on how to improve
- Continual development of ProHealth Best Practices and Metrics
- Advanced topic training
Recap: Key Success Factors

- Clear implementation strategy focused on 2 implementation goals:
  1. Physician Adoption
     - Right amount of training at right times
     - Incremental teaching, supported by hands-on re-enforcement of training
  2. Physician Productivity
     - Schedule reduction offset by improved efficiencies over time and when necessary, additional time slots added back into schedules over practice specified timeline
     - Every physician at these 30 practice sites met productivity targets within 12 months of go-live

- Flexibility of workflows and system functionality to meet needs of each practice, while maintaining standards of core policies/procedures surrounding patient care, disease management, billing etc.

- Focus on constantly improving

- Nimble governance
  1. Streamlined decision making (focus on getting things done)
  2. Dedicated PM and EHR MD (buck stops here)
  3. Shared accountability with practice leadership for implementation success
## Financial Benefits

- Reduction in transcription costs
- Reductions/reassignment in HIM/Medical Records staff
- Reduction in the cost of paper forms
- Reduction in Medical Records space
- Staff efficiencies in clinical and other operational units
- Volume and revenue enhancements
- Improved charge capture and collection of co-payments
## Qualitative Benefits

- Improved care coordination
- Reduction in the length of stay
- Improved discharge planning
- Improved medication orders and documentation
- Elimination of duplicate records
- Improved patient safety
- Reductions in duplicate testing
- Real time information and access to information
- Alerts for abnormal test results
- Restriction of access to patient information
- Regulatory compliance with HIPAA, JCAHO, and CMS
## EHR Total Budget with Offsets

<table>
<thead>
<tr>
<th>Description</th>
<th>Amount</th>
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<tbody>
<tr>
<td><strong>Total Approved Budget</strong></td>
<td>$127.5M</td>
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<tr>
<td><strong>Projected ROI Offsets/Incentives through 2020</strong></td>
<td>$108.7M</td>
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<tr>
<td>&gt; Transcription Savings</td>
<td>$4.5M</td>
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<td>&gt; Chart Supplies/Chart Pull Savings</td>
<td>$46.0M</td>
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<tr>
<td>&gt; Reduced Medical Records Staff</td>
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<td>&gt; Prior Ambulatory Systems Cost</td>
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<td>&gt; Prior Pharmacy Systems Cost</td>
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<td>&gt; Prior Inpatient Systems Cost</td>
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<td>&gt; Meaningful Use Incentive</td>
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<td>&gt; Physician Quality Reporting Initiative (PQRI)</td>
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<tr>
<td>&gt; eRx Incentive</td>
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<tr>
<td>&gt; Value-Based Purchasing Incentive</td>
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<tr>
<td><strong>Total System Cost</strong></td>
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*Federal policies for Value-Based Purchasing are still becoming understood. Scoring and payment scenarios are complex, and it is not possible at this time to project the financial offset from VBP.*
Summary: HARD ROI OFFSETS BY YEAR

<table>
<thead>
<tr>
<th>Year</th>
<th>Medical Records Offsets</th>
<th>Post-EHR Systems Savings</th>
<th>CMS Incentive Programs</th>
<th>Total By Year</th>
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<td>Transcription Services</td>
<td>Chart Supplies Management</td>
<td>Medical Records FTE's</td>
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<td>$ 2,342,649</td>
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<td>2020</td>
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<td>TOTAL</td>
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<td>$18,708,779</td>
<td>$33,434,630</td>
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Hard ROI Example

Total By Year
- $35,205
- $81,750
- $2,463,357
- $3,848,011
- $4,902,993
- $15,303,609
- $16,412,572
- $13,385,428
- $11,506,480
- $9,795,969
- $9,238,447
- $7,231,495
- $7,231,495
- $108,668,306
Additional ROI Benefits – Future Positioning

*The demands of the future will be very different than those of today*

- You must be able to demonstrate quality and benchmark patient care performance
- You must be able to demonstrate cost savings
- You must be able to demonstrate value
"Maintaining Physician Productivity and Revenue Cycle Performance Throughout an EHR/PM Transition"
CEENTA Overview

- Established in 1923.
- CEENTA is a 70 provider 14 location multi-specialty clinic located in the Charlotte Metrolina area.
- Specialties represented:
  - Ophthalmology
    - Including sub-specialists in Retina, Pediatrics, Plastics, Neuro-Ophthalmology, Cornea/Lasik, and Glaucoma.
  - Otolaryngology
    - Including Audiology, Allergy and Speech Pathology
  - Sleep Medicine
    - Including 2 in-house sleep labs and DME.
- A joint ventured on site ambulatory surgery center.
- First EMR installed in 2002
- Currently utilize 3 EMR systems with 3 others in house and transitioned.
Why would anyone want to do this the first time let alone multiple times!

- Mergers and Acquisitions.
- Concerns regarding support.
- Concerns regarding interfacing and speed.
- Concerns regarding Meaningful Use attestation.
- Specialty and Subspecialty Needs.
- Cost.
- Concerns regarding the practice management system.
Pearls for Administrators implementing or transitioning EMR’s

AKA Staying Employed and Staying Afloat

1. Set a goal and get physician buy in.
   – “A chart available for each patient at every visit”

2. Measure - “You can’t manage what you can’t measure”
   – Measure current cost of achieving the stated goal
     • Employee’s, Employee benefit cost, Faxes, Copiers, Shredders, Couriers, Folders, Supplies, Space etc.
     • Break this down to a manageable number for comparison.
       – Cost/Encounter.
   – Measure current revenue resulting from the stated goal.
     • Break this down to a manageable number for comparison
     • These numbers can be measured for multiple sub-sets within the practice or by individual physician
       – Revenue/Encounter

3. Plan your work and work your plan—AKA “a failure to plan is a plan for failure”.
   – Planning an EMR implementation or transition should take 2x’s as long as the implementation itself.
“A failure to plan is a plan for failure”

• Spend significant time looking at options for new or alternative EMR products.
  – Develop a list of must haves.
    • Two people in a chart at one time
    • Drawing
    • Interfacing to diagnostic equipment
    • Coding coach for ICD-10
    • Etc.
  – Develop a list of would like to haves.
    • Bio-identification
    • Image management
    • Inventory package
    • Sub-specialty modules
    • Etc.
  – Obtain RFP from vendors based on the requirements.
  – Chose the system that meets all the must haves and the majority of would like to haves.
  – Negotiate.
  – Follow the same process for hardware or off site storage.
  – We found that the software costs are usually 1/3 to 1/2 of the entire project costs based on the existing infrastructure.
  – Developed transition plans.
  – Measure each step of the way.
Pearls for Administrators implementing or transitioning EMR’s

AKA Staying Employed and Staying Afloat

• Transition plans
  – For a period of time you will be using double systems. What is the cost and how do you offset this?
    • How long will you pull paper records?
    • How long will you pay license and support fees for an existing legacy EMR?
    • How long will you utilize transcription services?
    • Are you able to add patients to the schedule?
  – You will not save significant amounts of money using an EMR system.
    • Savings are usually transitioned to IT costs. However, you want to assure you don’t spend more or you offset the costs with efficiency.
    • The length of the double system can add up quickly.
“A failure to plan is a plan for failure”
Transition Plan Processes for Migration
A case study

• Installed Greenway on our test servers.
  – This will require Greenway and on-site IT help for a short period of time. Manage this wisely.
  – Make sure that the data and the set-up are identical to production environment
  – Issues arose regarding the development of templates etc.
• Installed Greenway in a production environment for building templates etc.
  – Could not transfer some information from test. Be sure to identify this issue.
• Pull all current templates and pick lists from Medinformatix.
  – Looked at the utilization data for each template and built similar templates in Greenway.
  – Built “pick lists” similar to the ones currently in use.
  – Developed operational flow analysis comparisons between the current system and Greenway. “What do you do now”? What will we do in Greenway?
  – Identified issues and changes to our processes and developed training materials around these.
Greenway trainers focused on training our EMR team on template design and building.

- This will vary depending on the size of the practice and the amount of staff at hand. Measure the cost of training per person based on the contract and monitor this. This is one area that can grow quickly. May want to look at outside contract resources.

CEENTA’s EMR and training team handled training the staff as we were designing training around our current operational flow.

CEENTA’s team worked with Greenway to fill in holes in our process—Audiogram and Allergy.

“A failure to plan is a plan for failure”
Transition Plan Processes
“A failure to plan is a plan for failure”

Implementation

• Break the process into manageable pieces
  – Start with New Patients.
  – Front load as many of the upcoming appointments as possible with historical data.
    • training period and then prior to the appointments.
  – Reduce schedules in a very “measured” fashion.
    • “heavy hitters” (over 50 patients a day)
      – Reduce 4 patients a session morning and afternoon for the first week.
      – Reduce 2 patients a session morning and afternoon for the second week.
      – Return to normal schedule the third week.
      – Measure revenue - may want to look at additional clinic time.
    • “average hitters” (40 and over)
      – Reduce 2 patients a session morning and afternoon for the first week.
      – Reduce 1 patients a session morning and afternoon for the second week.
      – Return to normal schedule the third week.
      – Measure revenue - may want to look at additional clinic time.
    • “slow hitters” (30 and over)
      – Reduce 2 patients a session morning and afternoon for the first week.
      – Reduce 1 patients a session morning and afternoon for the second week.
      – Return to normal schedule the third week.
      – Measure revenue - may want to look at additional clinic time.
    • “no hitters” (under 30)
      – No reduction in schedule.
        – Start with only the necessary parts of the software – measure the return.
• Support those previously identified as needing additional help
• Communicate, Communicate, Communicate.
**“A failure to plan is a plan for failure”**

**EMR Migration**

1. Design and implement a demographic interface to the practice management system.
2. Prepare a test file of documents and images for export to the new system.
3. Greenway staff imports test documents and images into the Greenway EMR.
4. Verify export of all test documents and images.
5. Set a cut off date for the export of all documents and images. Prepare all documents and images for export.
6. Greenway staff imports all documents and images into the Greenway EMR.
7. CEENTA staff verified documents.
8. Go live – Staff given read only access or limited access to the Medinformatix system.
9. Final export 1 month after “go live”
10. Final import
11. Final verification
Hurdles

• Working with current EMR vendors to assure that the file exports out of the legacy system is successful.
  – They are usually not excited about your leaving.
  – Negotiate price and look for alternatives.- This can be costly and should be built into the total project cost.

• What do you migrate? Only documents or structured data?
  – We chose to move documents only.- Less expensive option
  – May vary with practice type.

• The transition weeks to close down old system
  – Transcription and outstanding orders etc.
  – Renegotiate license and support to potentially time and materials and limited licenses for the legacy system.

• Designing file location and access in Greenway
  – Use the KISS method.
Bottom Line

• Set a manageable goal that is well supported!
  – Goal should not be cost saving or compliance.
  – Most Doctor’s do not get happily on board when the goal is meeting governmental regulation and get very upset when the cost reduction goal is not met.

• You can’t manage what you don’t measure!
  – Measure current costs.
  – Measure future costs.
  – Determine what are needs vs. wants.
  – Break the project into manageable pieces from both an implementation and cost standpoint.

• A failure to plan is a plan for failure!
  – Spend the necessary planning time.
  – The EMR vendor does not know your practice and you will spend unnecessary dollars trying to teach them.

• Measure your success!
  – A happy administrator is an employed administrator.
Questions?

To learn more about replacing your EHR/EMR:
www.greenwaymedical.com/replace_EHR

Download our EHR replacement white paper: http://bit.ly/WW72pA

info@greenwaymedical.com

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