Dos, don'ts, and dollars: Making the switch to an EHR

↘ Strategies for implementing an electronic health record to enhance your practice's productivity and efficiency

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More and more ObGyns are adopting electronic health records (EHRs), not only to meet a government mandate but also with the hope of making their practice more efficient and productive. While it is likely that EHRs enhance qualitative benefits, such as safety, patient satisfaction, 24/7 availability of medical records, and patient access to medical data, it isn't always clear how they boost the financial bottom line. For this reason, we recommend that every practice "run the numbers" before making the transition from paper to paperless records. That means estimating the cost, expenses, and potential for added income associated with the EHR before embarking on the change.

In this article, we explain five ways a switch to EHRs can reduce costs. We also offer strategies for choosing and implementing an EHR, from information gathering to motivating your staff.

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Transcription costs are lower

The estimated cost of dictating a letter to a referring physician using conventional means is $12 to $15. That estimate includes the doctor's time, the cost of the transcriptionist, the stationery, and the postage or cost of faxing the letter. An ObGyn may generate five to 10 letters per day. That's $60 to $150 in expenses.

Most EHRs can generate a referral letter at no additional cost, provided the diagnosis,

ILLUSTRATION: PAUL ZWOLAK FOR OBG MANAGEMENT

How did we get here? A history of the EHR

Computers and electronics originally were used for administrative purposes and did not offer meaningful clinical applications when they first were introduced to health care during the 1960s and 70s.[8] These early machines were large, expensive, and slow and did not meet the practical needs of clinicians. During the 1980s and 90s, however, with networking capability and development of the World Wide Web, the potential for an electronic health record (EHR) became clearer. In 1991, an Institute of Medicine (IOM) report listed the "computer-based patient record" as "an essential technology for health care."[8] The authors of the IOM report envisioned a true network of practices and hospitals that seamlessly and efficiently share information and insight to increase quality of care, reduce medical errors, and improve patient safety.[1]

Despite advances in EHR technology, one major hurdle remained: cost. For many clinicians, the time and resources required for installation of the program, transfer of records to the electronic format, and training of staff was too high. By 2001, only 18% of physicians had incorporated the EHR.[2] Today, nearly 60% of practices use an EHR.

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prescribed medications, and treatment plan have been entered in the system. Not only that, but each referral letter can be transmitted immediately to the recipient by email (or fax; the referring doctor's preference). In the past, it may have taken as long as several weeks for the letter to be generated and make its way to the recipient by conventional means.

This use of the EHR can save a practice as much as $1,000 per physician every month.

Chart maintenance is no longer an issue

It sometimes can be a challenge for an ObGyn office to locate a paper chart. Any record lost in the "black hole" can wreak havoc with the schedule. It becomes even more problematic if the practice has multiple locations where charts are kept, delaying its recovery.

When a temporary chart must be created, it costs the practice time and dollars. It also becomes necessary to transfer the data into the permanent record, once it is located—another expense—not to mention the need to create a chart for every new patient.

It is not unusual for a busy practice to misplace as many as five charts a day, representing expenses of $25 to $50 per chart. With an EHR, this expense is reduced to $0, and the chart can be accessed 24/7 from multiple locations, including the physician's home or mobile phone, provided the EHR is networked between practices and the data are secured on the cloud (with encryption to ensure patient confidentiality and compliance with the Health Insurance Portability and Accountability Act, or HIPAA).

Another expense with paper records: pulling charts for the day's patients and returning them to the file rack at the conclusion of the day. These steps require additional employees and do nothing to improve patient care.

Coding is more accurate with an EHR

Prior to the development of EHRs, physicians had to guess the level of care that was provided and tended to "under-code" the visit, leading to a loss of income that the physician rightfully earned but didn't document fully. As one coding expert has noted, if you didn't document it, you didn't do it, and if the record reflects that you didn't do it, you can't be paid for it.

In general, the higher the level of care and the higher the code used, the more extensive documentation should be. Today's EHRs can automatically calculate the code best supported by the documentation entered at the time of the visit. After implementing an EHR, an ObGyn can ensure that accurate codes are submitted to payers, with higher levels of reimbursement honestly and ethically achieved.

A shift to EHRs frees up valuable square footage

It is not unusual for a practice to consume several hundred square feet of space for the storage of conventional medical records. Once a practice transitions to electronic records, however, these files are stored at a

remote site or shredded once the entire paper record has been scanned into the EHR. The office space once required for paper record storage can then be converted into examination rooms or devoted to a laboratory, imaging center, or procedure room to generate ancillary income.

There's an incentive involved

On February 17, 2009, the US government passed the Health Information Technology for Economic and Clinical Health (HITECH) Act in an effort to reduce the barriers to EHR implementation by outlining programs for standardization and funding of EHR programs.[1,2] The HITECH Act contained meaningful-use incentives to reward participants for the adoption of EHRs, with payments disbursed through Medicare and Medicaid.[2] By meeting several core objectives, individuals in private practice can earn as much as $44,000 over 5 years through the Medicare EHR incentive program and $63,750 over 6 years by participating in the Medicaid incentive program.[3] Hospitals can earn more than $2 million over the same period. The objectives differ slightly for hospitals and individuals but are intended to improve quality, coordination, and safety of care while promoting patient involvement and public health.[3]

The HITECH Act also sought to increase the security of EHRs to ensure patient privacy through standardization of EHR products. To become eligible for meaningful-use incentives, EHR software must meet government standards and specifications.[3] Common requirements include the ability to document:

- vital signs
- test results
- all medications and allergies.

Another requirement is the ability to generate lists of patients with common conditions.[3]

By standardizing the EHR format, the HITECH Act improved networking by physicians by ensuring common capabilities among various EHR products.

The funding and standardization established by the HITECH Act increased the usage of EHRs among physicians to 57% by 2011.[2]

How to implement an EHR

The first step is to narrow your options to a few vendors that best suit the needs of your office. This process is beyond the scope of this article, but your ultimate objective should be to choose a user-friendly interface from a vendor that offers excellent document security, customer assistance, and support.[4]

Form an implementation team for your practice, and have it **begin by consulting ObGyn practices of similar size that have recently installed one of the EHRs you are considering**. By asking about other practices' experiences and any pitfalls they encountered, you can greatly ease your transition to EHRs.

If possible, the physicians in your practice should visit the office of any colleagues who have implemented one of the EHRs you are considering to see how they like the product. Your office manager, nurses, and receptionist also should visit their counterparts in the other practice to ask about their experiences and opinions. The more information you glean from other ObGyn practices, the easier it will be to make your decision.

Be sure to check with your hospital to ensure compatibility with its system.

Ensure adequate technical support

One of the most important considerations in selecting a product is the availability and quality of tech support from the home office of the vendor. When you talk to other users of a product, ask how quickly tech support calls are returned and how efficiently problems are solved.

There will always be technical problems during the transition away from paper records. Ensuring their prompt resolution will be critical to your success.

Assign project management

After deciding on a particular product, create a project team to manage the complex, lengthy implementation process.[4–6] This

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Be sure to assess the availability and quality of tech support associated with any EHR product you are considering

team should include a project manager who has the experience and skills to coordinate a complex plan, a well-respected product champion who can help maintain staff support for the change, and several information technology (IT) specialists who can manage the software and hardware challenges.[4-6]

Rally the troops

The most vital part of any implementation plan is staff "buy-in."[4-6] It is incumbent upon the project-management team to determine what effects EHR implementation will have on workflow and to explain to employees how the process ultimately will increase efficiency and reduce work time and cost. And the project champion must remind employees of these goals during the transition.[4-6]

Develop a backup system

Work with your IT staff to create a backup system for the EHR to protect against system malfunction.[4] In the past, offices backed up their data to tapes or disks. Today, it probably is safer to back up to the cloud. Cloud computing, which allows for automatic back-up, is tightly regulated by HIPAA, so be sure to choose an approved vendor.[7]

Preload your data

Before going live with the EHR, data must be integrated and preloaded into the electronic format. This means integrating billing, lab results, orders, scheduling, and encounter templates into the EHR interface.[4,6] When data are preloaded, employees can practice on the software before the launch date, ensuring a seamless transition.[6]

No "teeth-gnashing" necessary

The transition to an EHR system can be intimidating and may affect your staff's productivity, efficiency, and morale. By following a few careful steps, the process can proceed without teeth-gnashing and loss of productivity. In fact, the suggestions offered here should improve productivity, office efficiency, and patient safety over the long term.

Who could ask for anything more? ⊘

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