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EMR Pushback

Bruce Landes, MD, is a confirmed skeptic when it comes to electronic medical records. But he insists he is no technophobe. "I am not a Luddite," Landes says, working up some steam on a topic he knows well. "Physicians are people who have been through the development of CT, MRI and robotic surgery. We are not afraid of technology, but we are afraid of bad technology."

By that he means EMR technology. Landes is the president and chief executive officer of Southwest Physician Associates, a Dallas-based independent physician association that encompasses some 1,300 physicians, most of them in small practices with fewer than five members. Like their peers across the country, these physicians primarily use computers for their practice management functions—the scheduling, registration and billing functions that are the lifeblood of their small businesses. But they have resisted adding clinical documentation to the technology mix, relying instead on paper charts.

"You have to realize that physicians have been trained four years in med school, then three to seven years in post-graduate training," Landes says. "The funny thing is that they want to take care of patients. They don't want to become specialists in creating medical records. They look at the medical record as an incidental cost of doing business. Many EMR programs act as if the medical record is the whole point of the patient encounter. It is just not."

Landes' view is not a unique one among doctors. Only a small percentage of physician practices have deployed EMR technology, according to a variety of surveys; a recent Accenture study put the figure at 11 percent. Other surveys suggest that EMRs are more common in larger medical groups with multiple sites—a setting that Landes acknowledges makes sense for clinical IT. But given the fact that the vast majority of medical physician groups are small, the low adoption rate is like a bucket of cold water in the face of the growing number of clinical IT proponents. Their contention that EMR will enhance patient safety, improve clinical outcomes and trim unnecessary expenses has fallen on largely deaf physician ears.

For many physician groups, the EMR represents expensive technology whose benefits accrue to others. Faced with dwindling reimbursement and increasing patient caseloads, physicians are reluctant to introduce technology that upends old habits and threatens productivity. Top that off with concerns over data security, and what appears to be intransigence can be understood as self-defense, if not common sense. "Physicians say they will go along with something and don't. Ten years ago we were talking about EMRs, and we are still talking," says Landes.

That reluctance, however, has not dissuaded a host of clinical IT exponents from pushing even harder for increased EMR adoption. Scores of vendors crowd the marketplace, showcasing their software "solutions" to physician woes at industry gatherings like HIMSS and TEPR (see "A Crowded Field," page 29). The federal government has relaxed its notoriously complex anti-kickback and Stark regulations that prohibited hospitals from subsidizing technology purchases for affiliated physicians; it also endorsed a certification effort now under way that sets minimum standards for EMR functionality. And a handful of payers are testing initiatives to spur adoption. Combined, these efforts may help EMR technology take root.

Lurking beneath the surface of the EMR glamour, however, are more primal motives. Vendors want customers. Hospitals want loyalty. Payers want efficiency. And patients? The Accenture survey revealed strong consumer support of clinical IT: Two-thirds said that electronic health records would figure into their selection of a physician.

A small but growing number of physicians are beginning to see the virtue in EMR technology. Sensing opportunity, hospitals, management service organizations and independent practice associations are taking steps to foster increased usage. But as the following stories suggest, the struggle for physician adoption is not going to be easy.

The MSO

A California provider hopes interfaces—and subsidies—can improve limited physician usage.

Newport Beach, CA-based Hoag Practice Management has been offering a hybrid EMR/practice management system to its 120 physician clients for the past six years. But Hoag, a management services organization that is a for-profit subsidiary of Hoag Memorial Hospital Presbyterian, has seen limited uptake on the EMR side of the equation. About 70 of the physicians use the EMR, from NextGen, which the MSO offers on a subscription basis, says Debra Spindel, Hoag's vice president. "The EMR is a huge change for physicians," says Spindel.

To ease the transition to the EMR, Hoag offers the technology using the application service provider model. Hoag uses an independent company to host the software, letting physicians sidestep expense and maintenance issues. "We are a full-service ASP," Spindel explains. "We offer a 24-hour help desk, plus we maintain and customize the

software." The combined EMR/practice management software offers integration between the billing side of a practice and the clinical documents that support it. In addition, physicians using the technology can share limited patient data with other NextGen users in the group—primarily patient demographics and insurance information.

Although Spindel declines to reveal the cost of the software for physicians, she says that physician EMR adopters have seen return on investment within one year thanks to enhanced revenue through better coding and labor savings through streamlined operations. Hoag Memorial Hospital hopes to expand adoption of the technology by offering physicians subsidies, now permitted under the relaxed Stark regulations. The local IPA, Greater Newport Physicians, is also offering subsidies, she adds.

With the economic boost, Hoag hopes to entice more physicians into the EMR fold as the program gets under way in fall 2007. As part of the package, the hospital will interface its own clinical information system with the NextGen software. The MSO also wants to build in a data exchange with local labs and imaging centers—thus, physicians could retrieve consolidated patient data through one application.

Although she acknowledges the slow pace of EMR adoption thus far, Spindel remains bullish on clinical IT, citing a seven-year plan that calls for 400 to 500 community physicians to be in the EMR fold. "There is a significant push for community interoperability," she says. "The beneficiary will be the physicians. They will get the product implemented at a lot less cost. One of the primary drivers will be getting the loyalty of the physicians."

The IPA

Scrapping data exchange, a Portland group hopes a bulk purchasing deal will promote adoption.

The Portland InterHospital Physicians Association is now officially in the EMR business. Since January 2006, the IPA has been a reseller of EMR software from eClinical Works, a Boston-based vendor whose clinical documentation tools are integrated with a practice management system. But Easterners are nowhere to be found in the EMR initiative. "We do our own installs, use our own trainers and have our own local people working with the physicians," says Maryclair Jorgensen, executive director of the Portland IPA and two other area IPAs that, in total, comprise roughly 2,500 physicians.

Jorgensen is thick in the battleground over physician EMR adoption. The three IPAs under her management include more than 840 practices of three physicians or less. "In Portland, we have only a handful of large group practices," she observes. "The small physician practices feel left out of the EMR discussion."

Jorgensen's foray into the EMR dealership offers a mini-history lesson in clinical IT. More than four years ago, the IPA considered launching a regional health information organization, or RHIO, that would facilitate data exchange among various healthcare players. RHIOs were all the rage then, sparked in part by President Bush's appointment of David Brailer, MD, to a newly created—and highly visible—clinical IT post. RHIOs popped up all over the country. But after three years of study, the IPA delayed the idea. "We were way ahead of the curve if we tried to put in a RHIO when physicians needed to get an EMR up first," she says.

Shifting gears, the IPA began evaluating potential EMR vendors. Sorting through the vendors was like wandering through a house of mirrors for Jorgensen. "It is mind-blowing to be looking at all these systems," she says. "They all start to look the same. And getting a firm price is hard." After taking a close look at 12 vendors, the IPA opted for eClinicalWorks. The vendor's resale model appealed to the IPA, which wanted to maintain as much local control as possible. "Some vendors wanted us to hand over our physician names to their marketing departments," she says.

Since January 2006, the IPA's sales effort has been in full swing. It has hired five staff who handle installations and training. Physicians buy the software outright, paying \$325 per physician per month for five years, says Jorgensen. The price includes implementation, training, support and upgrades, she adds. Physicians buy their own hardware. "The biggest fear of physicians was the unpredictable cost," she says.

In total, some 75 physicians have contracted for the EMR with roll-out dates through the fall of this year. The IPA completed 24 physician installations in its first year and is getting better at the implementations. Jorgensen says the IPA is courting another 70 prospects, but is careful not to move too fast. "Some physicians call and say they want an EMR next week," she says. "We tell them we will be prepared in 12 to 18 weeks. You need to analyze their workflow before you do the installation."

The Hospital

Physician demand sparks a \$2 million investment—or is it more of a gamble?

One EMR stereotype is that doctors normally assume the role of resistance fighter, hunkering down against the introduction of technology into their practice. Not so in Joliet, IL, a bedroom community about 50 miles southwest of downtown Chicago. There, in 2005, a group of physicians approached the CEO of Silver Cross Hospital and asked for help with EMR adoption. "They wanted to be ready for pay-for-performance and figured that one day EMRs

would be required," recalls Matt Ebaugh, vice president and chief information officer.

Heeding the physicians' call, 240-staffed-bed Silver Cross has invested some \$2 million in EMR hardware and software. Adopting the ASP model, it will host software from Misys, offering the vendor's combined clinical documentation-practice management system to area physicians on a subscription basis. "Our rallying cry is around patient safety," the fast-talking Ebaugh says. "We will integrate Silver Cross' information system with Misys so the data exchange will be seamless. Physicians won't have to toggle between systems. They can use their EMR to get at our data."

The Silver Cross effort was under way before the relaxed Stark regulations were announced. But the hospital is still taking pains to make sure it complies with the law, Ebaugh says. "We are not making any money, nor is the physician getting any subsidy," he says. "It is a break-even model that we are doing for physician and community benefit."

To participate, practices subscribing to the hybrid practice management/EMR system would pay an annual fee of approximately \$8,000 per physician for five years, Ebaugh says. The price would drop substantially afterwards. "This is due to the initial ramp up of all the hardware and storage infrastructure that is required for the ASP," Ebaugh explains. Because Silver Cross hosts the software, physicians can sidestep shelling out as much as \$40,000 for a server and maintaining their own infrastructure. Physicians would be responsible for buying their own access devices and DSL line. However, the price does include tech support. "We don't want physicians going to Misys with tech problems," Ebaugh explains. "The issue may be something on our end, and we are also trying to brand this as a Silver Cross program."

Silver Cross has a sizable market to court. The hospital has a medical staff of 450 physicians, of which 160 fall into the active admitter category, Ebaugh estimates. Representing an array of specialties, a steady stream of physicians has joined the program, which offers the option of data sharing with other groups in the network. By the end of 2008, roughly 180 physicians—predominately in small group practices—will have contracted to be in the program, Ebaugh says. "It is our active admitters who are signing up first," he says.

In addition to toeing the line with Stark rules, Silver Cross is careful in how it presents data-sharing opportunities to physicians. Doctors may be reluctant to share clinical data with other practices, so Silver Cross is letting physicians make the final call—for now. "We are trying to avoid a collapse like they had in Santa Barbara," he says, referring to the demise of a well-known community data exchange that ceased operation last year. "But our focus is the patient, so we may make data sharing a condition of participation at some point."

In the long run, Ebaugh figures Silver Cross' technology strategy will pay off. "Physicians don't have the money or geek squads running around to support clinical IT," he says. "Doctors need a parent to support them."

The Payer

Creating an online source of data for patients—so where's the data?

With the vision of reducing costs and improving quality, in 2004 Health Care Service Corp. launched "Blue Care Connection," a Web-based source of health records and content for consumers. The service is available to 11.5 million members in the Blues plans that HCSC runs in Illinois, New Mexico, Oklahoma and Texas, according to Joe Taylor, vice president of enterprise business process, and it includes a personalized payer-based health record intended to show tests patients have received and help them monitor what needs to happen next. In the case of chronic illness, such as diabetes, such monitoring can help sidestep costly hospitalizations and complications.

Ideally, the portal would pull together data from the payer's own claims histories as well as data from physician practices. Yet the low adoption rate of EMRs in physician practices has made the physician component of data collection next to impossible; to date, no doctors are supplying data. "There are a lot of questions around who owns the data," Taylor says. "Until those questions are resolved, physicians may not want to share with us and put their data in our system. We understand that perspective."

Hoping to whet physicians' appetite for electronic data, HCSC will offer a streamlined version of a patient chart to physicians through a company called Availity. The physician service may spark interest in EMRs, says Taylor, who acknowledges that the payer is not attempting to persuade physician adoption. When launched, the Availity portal will consolidate HCSC data from claims histories and give physicians "a high-level view of what is going on," Taylor says. The portal, for example, would show what lab tests have been ordered. But until HCSC works out a deal with major labs, the results will not be part of the portal.

Meanwhile, work continues on the Blue Care Connection portal, with HCSC adding data from its own files. Eventually, consumers would be able to supply their own data, Taylor says. Exactly how the two services will integrate with physician and hospital data is unclear. But the more data that physicians capture electronically and the more they are willing to share it, the better likelihood that HCSC's vision will become reality. "Blue Care Connection is not a substitute for an EMR," Taylor says.

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A Crowded Field

If EMR adopters agree on one thing, it is that the marketplace of software vendors is way too crowded. "Go to the HIMSS show, and there are hundreds of vendors with EMRs," says Lewis Redd, managing partner for Accenture's Health and Life Sciences division. "The industry cannot afford that many versions of an EMR."

Maryclair Jorgensen, executive director of the Portland InterHospital Physicians Association, got an object lesson in vendor proliferation when the IPA began searching for an EMR vendor in 2005. Before settling on eClinicalWorks, the IPA evaluated a dozen vendors. Originally leaning toward GE Healthcare, whose software is widely used in the Portland area, Jorgensen had difficulty getting a firm price from the Milwaukee-based vendor and backed off. Other vendors turned out to be little more than smoke and mirrors. One company turned out to lease much of the software it presented as its own, she says. For Jorgensen, vendor longevity was a critical factor in picking a software partner. "When we started, we identified 370 companies and wanted to make sure we picked one that would be around," she says.

The multitude of vendors reflects the nature of the sprawling physician market, itself characterized by small businesses, says Redd. "You have mom-and-pop businesses serving a few physicians," he says. "You will always have vendors operating out of a garage because that is the nature of the beast. There are so many physicians, it spawns a 'many-to-many' environment."

Large hospital information systems vendors, like GE and McKesson, have purchased EMR companies targeting physician practices. Having a well-heeled corporate parent may give some edge to the EMR brand, Redd says. But he adds that the hospital information system giants are not going to launch sales campaigns to sell their EMR line to physician practices. Rather, they will appeal to large hospital systems that may be looking for inroads to the local physician market. "They are more likely to sell to a large academic medical center than going door to door," he says.

—Gary Baldwin

Taking the Plunge

Ask Mike DeMaertelaere, DO, what compelled his eight-physician group practice to take the EMR plunge this past summer, and without hesitation he'll say, "Quality of life." By that the family physician means that keeping an organized, well-documented patient record was proving to be impossible with paper charts. "The scope of primary care is so large, we have to track everything from diabetes to back pain," says DeMaertelaere, a member of Hedges Family Practice Clinic, in Frankfort, IL. "We need a better organization of data to help patients. And we needed better documentation to support our coding. We often undercode because we are afraid of an audit, so we don't charge for all the things we do."

Despite the potential of EMR technology to address those concerns, Hedges Clinic had never researched vendors on its own. Only when approached by Silver Cross Hospital, a community facility in nearby Joliet that was offering to support an EMR initiative, did Hedges move forward. DeMaertelaere cites four reasons for the practice's reluctance to adopt EMR technology: cost, impact on workflow, server downtime and data control.

After considering Silver Cross' proposal, the practice forged ahead, contracting with the hospital early in 2007. The practice will lease the software, which will be hosted by the hospital. The setup helped Hedges avoid major infrastructure costs. In addition, DeMaertelaere was sold by projections showing how the group could increase revenue through better coding. It would also pay less for its malpractice insurance after implementing an EMR, he says.

To assess the software's effect on physician workflow, Hedges called in the vendor, Misys, for a private demonstration about six weeks before signing on. "We let the physicians go through typical patient encounters with Misys showing us how the documentation templates worked and how we would generate a note," he says.

Concerns over data privacy were allayed by the contractual language that Silver Cross built into the contract. Even though having many community practices on the same EMR system would facilitate data sharing, it is left to individual practices to determine who can gain access to their files. DeMaertelaere is less concerned about hackers gaining access to the system. "There is so much billing and patient information sent electronically to insurers that that risk will always be there anyway," he says. As to downtime, DeMaertelaere says it is a "risk we are willing to accept."

—Gary Baldwin

The 'Moral Hazard' of Electronic Documentation

Ethics are not usually part of the EMR debate—unless you talk with Bruce Landes, MD. As president and CEO of Southwest Physician Associates, Landes has done a fair share of analysis of EMR technology, describing it as “a good example of bad software.” Landes’ IPA comprises predominately small groups—of five physicians or less. And while he’s heard all the arguments about why they should automate their clinical documentation, he has a few of his own why they should not. Chief among them: the “moral hazard.”

Physicians, he explains, may be tempted to use an EMR because of the economic enticement of eliminating costly transcription services, which can easily hit tens of thousands of dollars annually per physician. Instead, they would use computer-driven templates to create their notes. The problem, Landes says, is that the savings of transcription come at the expense of productivity. “You have turned your physicians into transcriptionists” with the EMR, he says. “And when a physician becomes a transcriptionist, he looks for shortcuts.”

Faced with creating their own documentation of a visit, physicians will use templates or computer macros to describe what they have done. The result? “If you create a medical record out of a macro, you have a record that can fit any patient who walks in the door,” says Landes. “You can wind up with a record that is totally useless.”

As a case in point, Landes describes physician charts created using EMR technology. Reflecting cut-and-paste functions, or perhaps prewritten templates, the narrative will include duplicate or redundant phrases—sometimes with absurd results. In one chart, for example, Landes saw the phrase “first time seen patient” three times. “What can I trust about the rest of that report?” he asks.

—Gary Baldwin

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