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ELECTRONIC HEALTH RECORDS:
GO BEYOND THE PAIN AND GET TO THE BENEFITS

Sometimes old habits are hard to break. Take medical records, for example. As long as doctors have been helping patients, they have developed ways to keep track of crucial health information in a handy chart form. It was easy to look at previous data, write notes about a suspected diagnosis, and keep a record of patient discussions.

This practice worked admirably for many years, and practitioners became accustomed to pulling out a chart and making a quick review prior to entering the exam room. Along the way, however, changes occurred that made keeping health records in print format less advantageous:

- Practices grew to the point where they were required to maintain thousands of records for extensive periods of time. Storage became an issue, with some practices adding on extra space to hold all the current and legacy charts or paying an additional monthly storage cost.
- The charts began to get thicker. Patients live longer, or have more extensive medical complications. They might require a battery of tests for a diagnosis, with all the results manually added to the chart.
- Administrative costs continued to increase as practices hired additional staff to pull charts, file charts, and handle the filing tasks. Constant training was required to ensure that each person maintained the chart in the same manner so providers could instantly access necessary information by finding it in a specific order.
- Anything relying on interpreting human handwriting is fraught with danger. Medications can be prescribed improperly or time is lost as office staff try to get the provider to clarify what a certain word is supposed to be. In the worst case scenario, a care error is made causing pain, discomfort or worse for the patient.
- Charting is an inefficient use of time. The provider takes notes during the exam, dictates them at a later point (hoping to remember everything correctly), and a staff member transcribes those notes into written format – again, hopefully understanding the provider's meaning and utilizing the correct medical terminology.
- Natural disasters can occur at any time in any location. From hurricanes in Florida to wild fires in California, it is easy to see how quickly a medical practice can be destroyed along with all of its records. Without any form of back-up, it can be next to impossible to quickly get the practice up and running again.
- Perhaps one of the least effective uses of time in a medical practice is sharing information with other providers. The healthcare provider may need to take time to review the record and dictate a response to a request, or valuable office time and resources are wasted in simply copying and forwarding records. Although practices do charge the patient for this service, it often leads to a negative feeling.

THE CASE FOR ELECTRONIC HEALTH RECORDS

Despite all of the inefficiencies, delays, costs and the huge potential for error, some medical practices continue to utilize the paper form of health records, and resist the effort to go paperless. They feel comfortable with the known quantity, are concerned about the expense of switching, or are simply afraid that the benefits will not be worth the investment involved.

While it does require a concentrated effort on the part of the entire practice team to successfully implement an Electronic Health Record (EHR) system, many practices have already done so and are happy with the results. Some were not happy with the system selected, and had to try again. Although it was mostly early adapters or those looking to take advantage of incentives that jumped on the EHR bandwagon, the rest of the practices will not have a choice in the matter very soon.

As a part of the American Recovery and Reinvestment Act, all public and private healthcare providers and other eligible professionals (EP) were required to adopt and demonstrate "meaningful use" of electronic medical records (EMR) by January 1, 2014 in order to maintain their existing Medicaid and Medicare reimbursement levels.

The final rule, published August 14, 2017, puts additional emphasis on data sharing and interoperability, while relaxing specific components, including the shorter reporting period. Continued compliance can result in maximizing points under the Merit-Based Incentive Payment System (MIPS) for promoting interoperability. Non-compliant practices may face financial penalties in the form of reduced Medicare reimbursement.

Practices that successfully implement an EHR system will recognize many benefits including:

- Less space required for paper records means more space available for productive office activities.
- Better use of administrative personnel.
- Increased accuracy with direct input to the record instead of relying on a transcriber.
- Easier exchange of information.
- Speech recognition capabilities enable more efficient data input.
- Cloud backup capabilities so no information is lost due to natural disaster.

According to HealthIT.gov, "When health care providers have access to complete and accurate information, patients receive better medical care. Electronic health records (EHRs) can improve the ability to diagnose diseases and reduce – or even prevent – medical errors, thereby improving patient outcomes." The website quotes statistics from a national survey of doctors who are ready for meaningful use which found:

- **94% of providers report that EHR makes records readily available at point of care.**
- **88% report that EHR produces clinical benefits for the practice.**
- **75% of providers report that EHR allows them to deliver better patient care.**

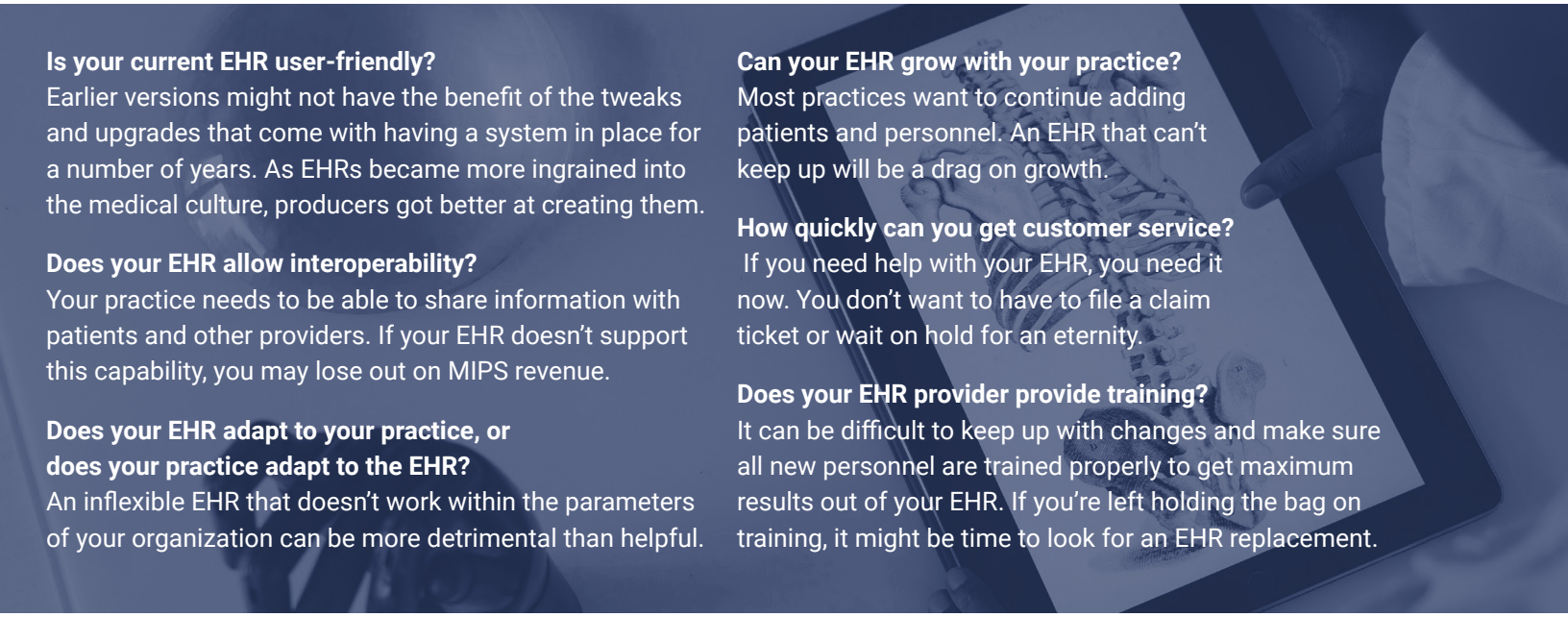
With an effective EHR, the provider has reliable access to a patient's complete health information, which can lead to a quicker and more accurate diagnosis. In addition, EHRs can assist in Risk Management and Liability Prevention efforts due to the ability to aggregate, analyze and assess all patient information in one place. They provide an easily legible record in the event a lawsuit is filed against the practitioner.

Finally, and perhaps most importantly, EHRs provide an invaluable assist to the billing task. Information is gathered quickly and accurately, and can easily be sent on to the insurance company or government entity for claims processing. This results in better Revenue Cycle Management.

HOW TO DETERMINE WHEN IT IS TIME FOR EHR REPLACEMENT

EHRs are, at their simplest, digital versions of patients' paper charts. But they can be so much more than that, especially when operating at maximum strength. Some of the early adapters are finding their old EHR system is not capable of keeping up with their currentday requirements, and are actually beginning to cause more administrative pain than they alleviate. Due to the updated regulatory requirements or increased practice needs, their initial EHR choice might be causing a series of difficulties.

Many are planning EHR replacement options within the next few years. Here are some questions to ask to help determine whether it might be time for an EHR replacement at your practice:



Is your current EHR user-friendly?
Earlier versions might not have the benefit of the tweaks and upgrades that come with having a system in place for a number of years. As EHRs became more ingrained into the medical culture, producers got better at creating them.

Does your EHR allow interoperability?
Your practice needs to be able to share information with patients and other providers. If your EHR doesn't support this capability, you may lose out on MIPS revenue.

Does your EHR adapt to your practice, or does your practice adapt to the EHR?
An inflexible EHR that doesn't work within the parameters of your organization can be more detrimental than helpful.

Can your EHR grow with your practice?
Most practices want to continue adding patients and personnel. An EHR that can't keep up will be a drag on growth.

How quickly can you get customer service?
If you need help with your EHR, you need it now. You don't want to have to file a claim ticket or wait on hold for an eternity.

Does your EHR provider provide training?
It can be difficult to keep up with changes and make sure all new personnel are trained properly to get maximum results out of your EHR. If you're left holding the bag on training, it might be time to look for an EHR replacement.

Unless you have upgraded your EHR, you may also miss out on some of the latest advantages that might not have been envisioned when your system was first created. Functions like mobile access, patient portal integration, cloud storage and back-up, and secure communications are now the norm in EHR efficiency.

New Features

- Mobile Access
- Patient Portal Integration
- Cloud Storage & Back-up
- Secure Communications

HOW TO DECIDE WHICH EHR IS THE BEST FIT FOR YOUR MEDICAL PRACTICE

If you do decide that your practice needs an EHR replacement, one of the biggest challenges will be managing the data migration from the old EHR to its replacement. You'll need to develop a step-by-step plan with a specific testing phase and "live" goal. Talk to your staff and come up with a list of requirements based on your practice and specialty needs, and compare your needs against what the various vendors provide.

Make sure you work with a company that will help make the process proceed efficiently.
Other factors in deciding which EHR is best for your medical practice include:

Impact
What time, dollar and manpower resources are needed to replace your EHR?

Usability
Is the EHR appropriate to your current and future practice needs?

Interoperability
Does it support patient communication and the exchange of information with other providers?

Flexibility
Can you make adaptations that make it fit your specific requirements?

Upgrades
How often is the system upgraded to meet current regulations and capabilities?

Cost
What do you receive in terms of training, support and coordination for the money you pay?

Reputation
You want to work with a company that has experience and a strong reputation in the EHR field.

Explore your EHR options at www.amazingcharts.com

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