EHR to EHR Conversions
What you Need to Know

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MOUNT KISCO MEDICAL GROUP PC

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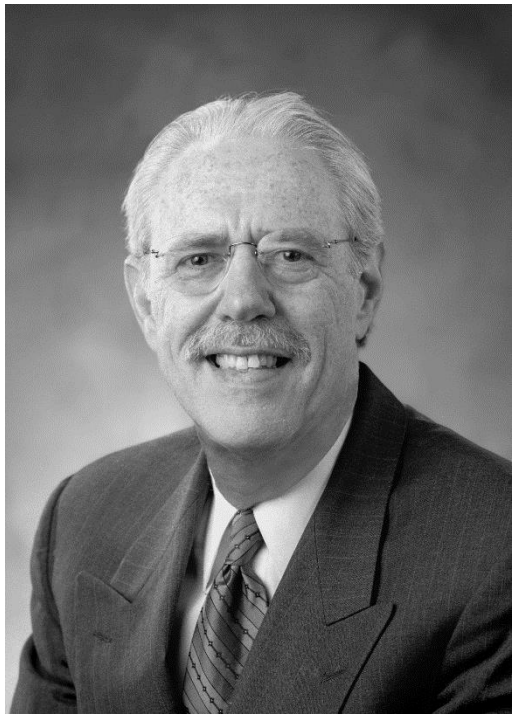


MKMG
MOUNT KISCO MEDICAL GROUP PC

Dr. Abe Levy graduated from the University of Tennessee Medical School, and completed his Internal Medicine Internship and Residency at Sinai Hospital of Baltimore, and a Fellowship in Psychosomatic Medicine at the University of Rochester, after which he served as an Assistant Professor of Medicine & Psychiatry.

In 1974, he joined the Mount Kisco Medical Group (MKMG) and practiced for 22 years as a general Internist. He served 15 years as MKMG's first Medical Director, becoming Chief Quality Officer in 2004.

MKMG met Meaningful Use for 181 of 182 eligible providers in 2011 and 2012, is recognized by NCQA as a level 3 PCMH, and became an ACO in 2012.

He is a past-president of the Westchester Academy of Medicine and the Westchester County Medical Society. He served on the AMGA Public Policy Committee and was Chairman of the AMGA-PAC for the last 4 years.

Mount Kisco Medical Group History

- 300 physician group with 50 additional healthcare professionals and 300,000 active patients
- 26 offices in 3 counties in the lower Hudson River Valley north of New York City (60 mile diameter)

Mount Kisco Medical Group History, cont.

- 40 specialties and sub-specialties in all areas except behavioral sciences
- State of the art Clinical and Pathology Laboratories in-house plus all diagnostic imaging services

Long-standing emphasis on highest quality physicians and on the best-of-breed diagnostic equipment

Mount Kisco Medical Group History, cont.

- Decade-long effort at employee satisfaction and 5 years of emphasis on patient satisfaction
- 181 / 182 providers met Meaningful Use in 2011 and in 2012
- 60 Primary Care Physicians in 12 offices recognized by NCQA as Level 3 PCMH
- ACO of MSSP type started in April 2012

Important Information

75 MKMG Physicians Named Top Docs By US News

41 MKMG Physicians Named Top Doctors By Westchester Magazine

EMR's x 3

1. Our first EMR, Practice Partner, launched February 1998. It was primarily a data repository of physician notes.
2. We converted 100% of these notes into our second EMR in December 2001. Began 10 year successful partnership including
   a) Implementation of electronic lab ordering and resulting
   b) Radiology ordering and resulting
   c) eRx for over 500,000 prescriptions per year

EMR's x 3 cont.

d) In December 2004, our Board of Directors declared the EMR to be the official record of care at MKMG with no paper stored.

e) In 2010, the collaborative relationships with dozens of support staff, analysts, and executives at our EMR partner were jeopardized when that company merged with another vendor, and the new company decided ***not*** to make the EMR we were using meet Meaningful Use.

EMR's x 3 cont.

f. After carefully weighing the option of purchasing a new EMR from the same vendor, we decided to purchase a new EMR from a different vendor.
   i. Fundamental goal was a single database for both EMR and PM.
   ii. Second important goal was to recreate at 'go-live' the dozens of relationships with support staff and executives at the new vendor "instantly".

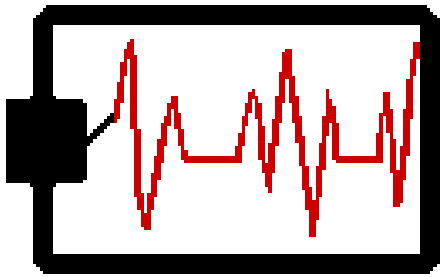
Conversion Process

Goal: Conversion of 13.5 years of data to the new EMR.

- **We could not locate a conversion vendor to assist with the process.**
- **MKMG hired 6 Business Analysts with experience in financial software as well as healthcare.**
  - **Tasked with understanding the complete table structure of the old EMR, so that they could extract the data and deliver it to the new EMR.**
- **Decision made to convert virtually 100% of data. The only data not converted were "deleted Tasks". Open and completed tasks were converted.**

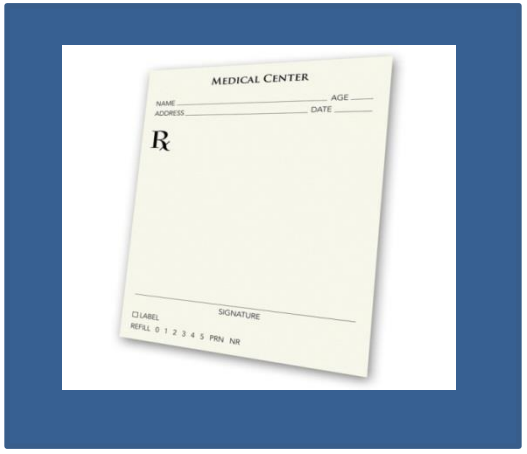
Conversion Process cont.

- 40 million laboratory results converted and simultaneous initiation of LOINC for all future results.
- 12.5 million chart notes converted.
- Over 100,000 EKG's converted (blobs).



Conversion Process cont.

- Open orders for Lab and Radiology as well as refillable prescriptions, transferred into new EMR.
- Open, completed, and future Tasks converted into the new EMR.



Unforeseen Problems & Challenges

- "Loose Mapping" of identities resulted in erroneous transfer of data with 250 charts out of a total of 600,000. These were corrected and re-mapped to regain data integrity.
- Unforeseen multiplication of "document types" or categories for chart notes and other documents resulted in an increase from 1,500 types to almost 6,000. Project initiated which lasted over a year to merge document types into the original 1,500.

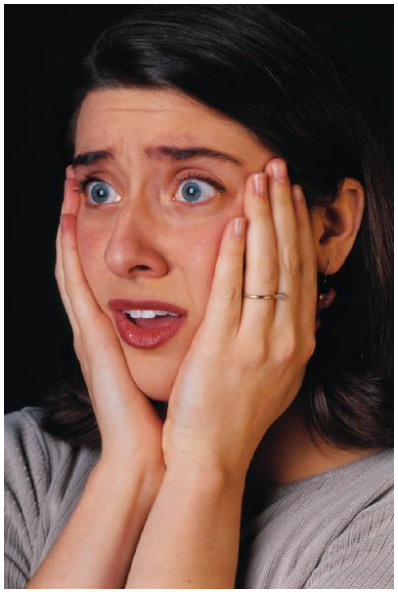
Unforeseen Problems & Challenges, cont.

- We learned the importance of tight data integrity in the EMR database.
- Take home lesson: Successful major conversion of EMR's requires hiring a team of Business Analysts with deep expertise in HL-7 interfaces and the database table structure of EMR's.

EMR Conversions –

Not for the faint of heart!

- There is no guarantee that you will be successful in converting your data.
- Your own IT department must learn the table structure of both the old and the new EMR, but especially the old one.
- Risks must be taken.



EMR Conversions –

NOT FOR THE FAINT OF HEART!

EMR conversions cannot be gradual in the way that a first EMR implementation can be.

A physician cannot take care of a patient using 2 EMRs.

We turned off access to the old EMR at go-live on the first day except for the Nurse Manager in each building or department.

EMR Conversions –

NOT FOR THE FAINT OF HEART!

A specialist and a PCP must be on the same EMR at all times, so a gradual implementation of an EMR conversion is not possible.

A true partnership between the CIO, CMIO, Business Analyst team, and especially the clinical and business managers who build the new tables is critical to success.

***Jeffery Daigrepont*, Senior Vice President of Coker Group, specializes in health care automation, strategic planning, operations, and deployment of fully integrated information systems for medical practices and hospitals.**

A popular program speaker, Jeffery is frequently engaged by highly respected organizations across the nation. Accomplishments include the authorship of several publications and Mr. Daigrepont is often interviewed in industry publications. For FY09, Daigrepont chaired the Ambulatory Information Systems Steering Committee of HIMSS. In addition, as the Ambulatory Committee liaison for FY09 to the ACEC planning Committee, he represented the HIMSS Ambulatory and AISC members.

Daigrepont is credentialed by the American Academy of Medical Management (AAMM) with an Executive Fellowship in Practice Management (EFPM).

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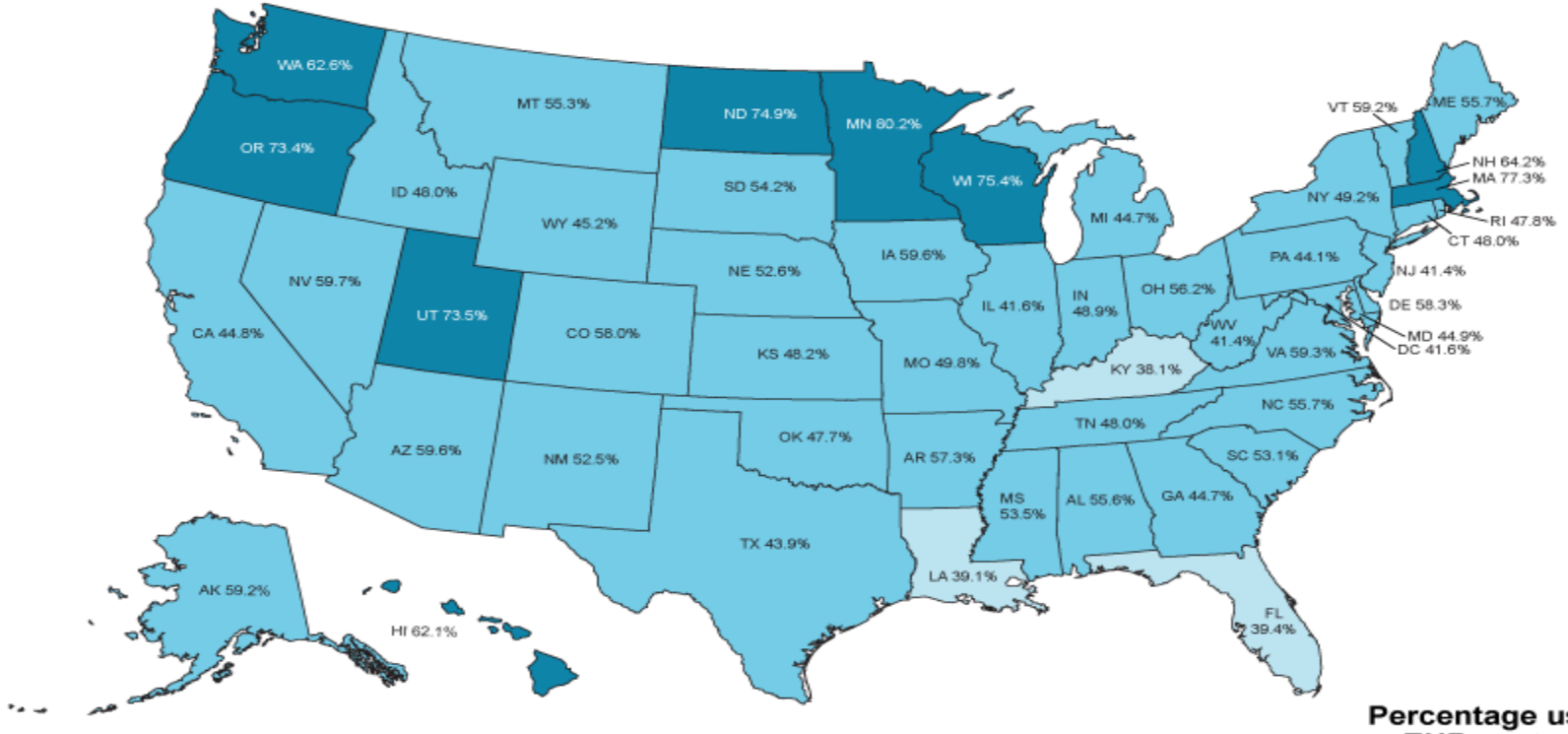
Agenda

- Current State of the Market
- Why EHRs Fail
- Should You Replace Your EHR?
- Steps to Move Forward
- EHR Replacement and/or Optimization Benefits
- How to Prevent Future Failures

Current State of the Market

Figure 2. Percentage of office-based physicians using any electronic medical record/electronic health record (EMR/EHR) system, by state: United States, preliminary 2010



NOTE: Significance tested at $p<0.05$.
SOURCE: CDC/NCHS, National Ambulatory Medical Care Survey.

MEANINGFUL USE-EHR INCENTIVES

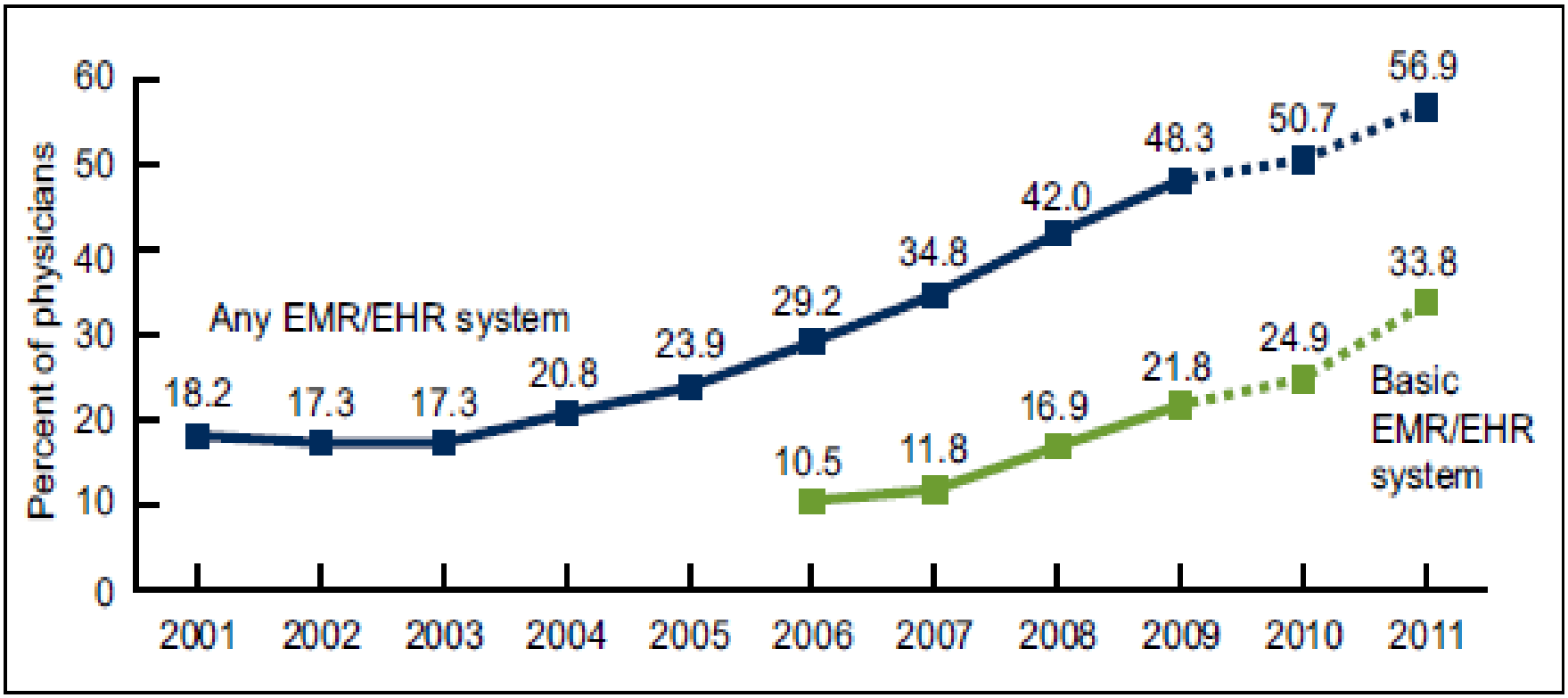
- CMS paid out $2.5 *billion* in EHR incentives during 2011 to hospitals and physicians*

- EHR adoption rates have increased due to the incentives – in practices and hospitals (43 states have launched Medicaid programs)
- Greatest physician concern = decrease in productivity
- Practices are still experiencing dissatisfaction resulting in de-installs and replacements

**Source*: www.govhealthit.com/news 1/10/2012

EHR Adoption Rate

Figure 1. Percentage of office-based physicians with EMR/EHR systems: United States, 2001–2009, and preliminary 2010–2011



Source: CDC/NCHS – National Ambulatory Medical Care Survey; www.cdc.gov/nchs November 2011; posted 1/20/2012

US Physician Population*

	1990	1995	2000	2007
Total Physicians	615,421	720,325	813,770	941,304
Hospital-Based	142,875	154,856	157,032	169,337
Residents / Fellows	92,080	96,352	95,725	98,688
Full-time staff	50,795	58,504	61,307	70,649
% of total - full-time staff	8.3%	8.1%	7.5%	7.5%
% growth in Hospital-based		8%	1%	7%
Physicians by Activity, 1975-2007, p. 406				
AMA and The Coker Group, 2009				

- *This data was included to reflect the updated number of practicing physicians in the US.*

MARKET SHARE CLAIMS (BY VENDORS)*

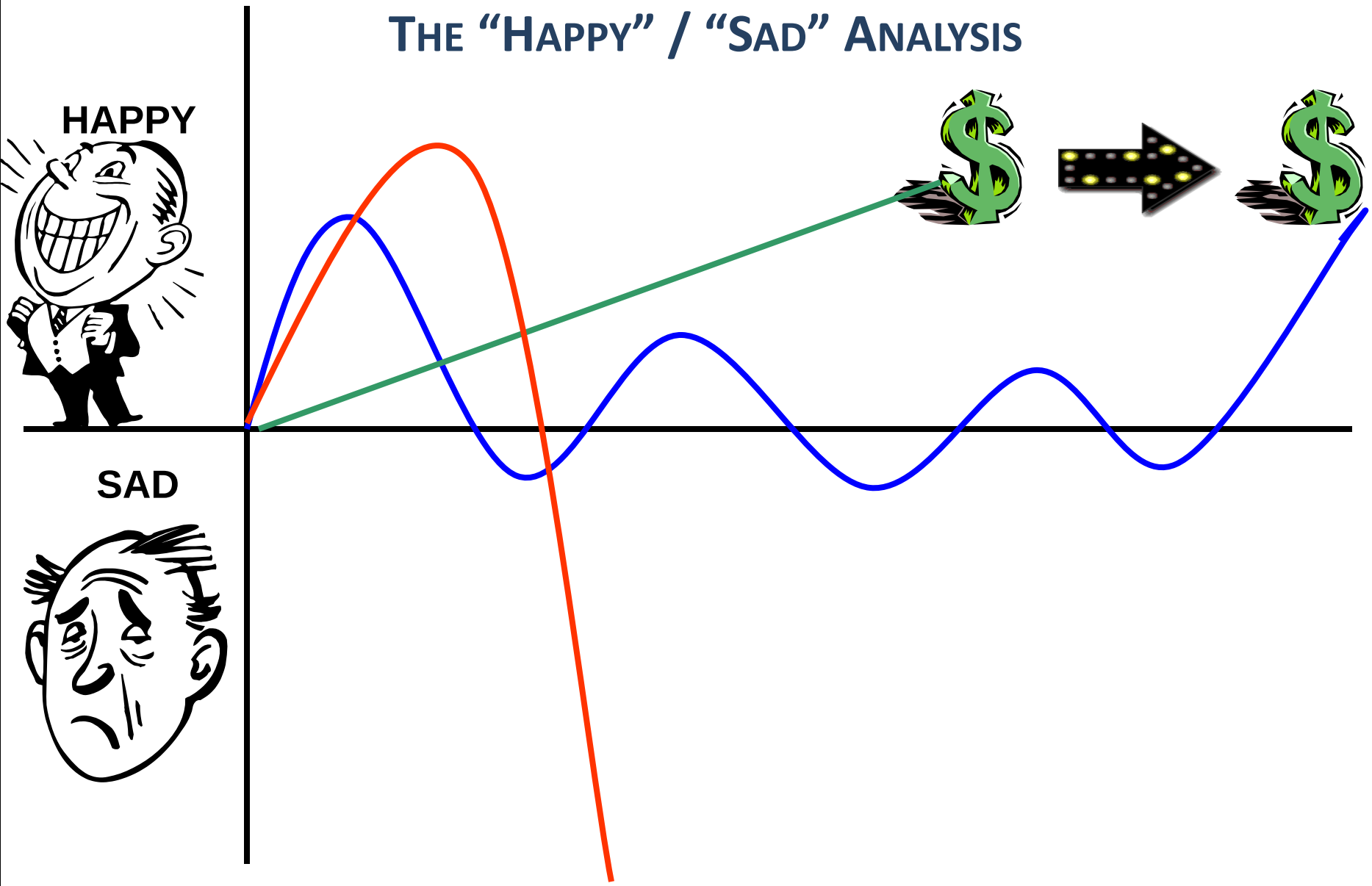
Vendors	Acquired products & solutions	Market Share Claims by total Number of providers
Epic	NONE - 100% organic	150,000
GE	Millbrook, Logician, IDX FlowCast, IDX GroupCast, IDX CareCast, EDI - Company claims to have 20% of the ambulatory market	148,000
Sage	Medical Manager, Emdeon, PCN, Verses	107,000
McKesson	Horizon, Practice Partners, MediSoft, RelayHealth	129,000
Misys/Allscripts/ A4	HealthMatics, Compusense, Medic, Tiger, Vision, TouchWorks, ImPact, PenChart. Company claims 1 in every 3 physicians use one of their products/solutions	247,000 (reported) 200,000 (actual)
NextGen	Originally 2 products (10 years ago), mostly organic - both products have been fused together	50,000
eClinicalWorks	NONE - 100% organic - Single version solution	20,000
Greenway	NONE - 100% organic - Single version solution	4000
LSS Data Systems	NONE - 100% organic - Single version solution	
athenahealth	NONE - 100% organic - Single version solution	17,000
Cerner Ambulatory	Several (VitalWorks consisted of several legacy products)	37,000
e-MDs	NONE - 100% organic - Single version solution	7000
Practice One	N/A	5000
MED3000	VAR - Non-applicable	NA
Henry Scheine	Medical Supply company (Acquired vendor)	NA
HealthPort	Formally Companion	4000
Others (35+)	There are 35 additional CCHIT vendor not considered here	?
	TOTAL	**925,000**
	Estimated Actual	**675,000**

•*This data was included to show the differences between vendor claims and market share realities reflected in Coker's data*

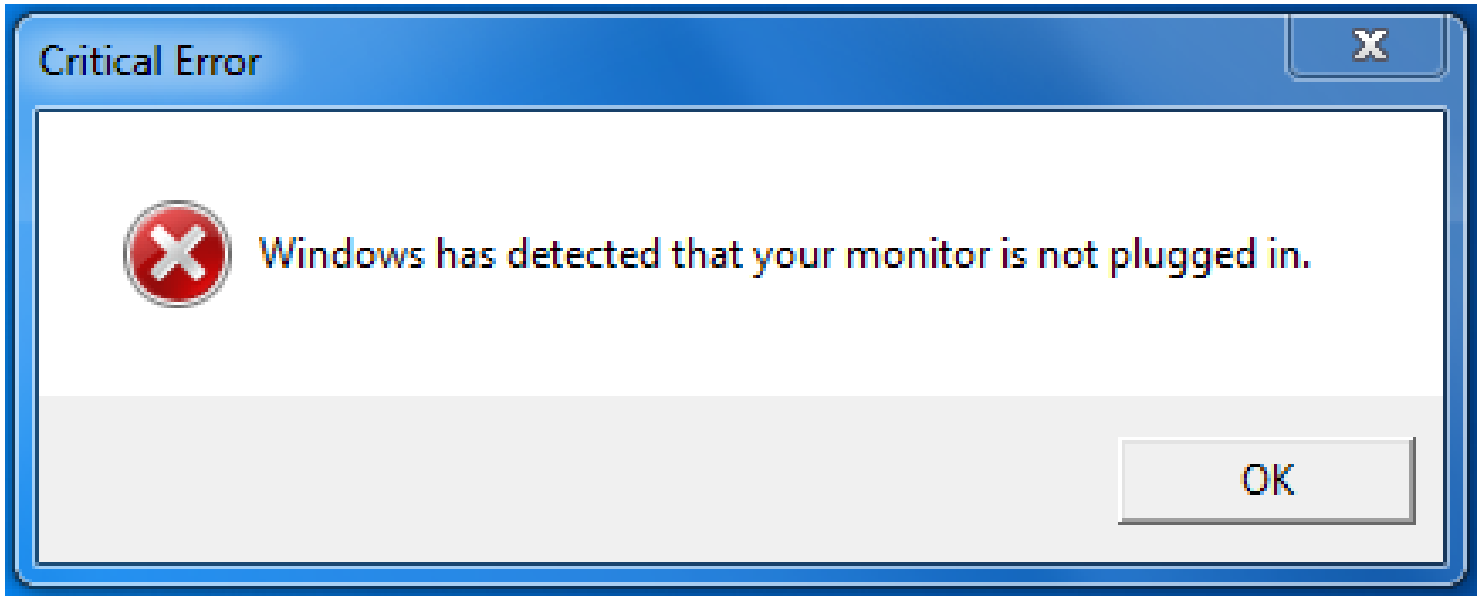
CURRENT STATE OF THE VENDORS

Why EHR Typically Fail

Implementing Technology
The "Happy" / "Sad" Analysis



Possible Causes…



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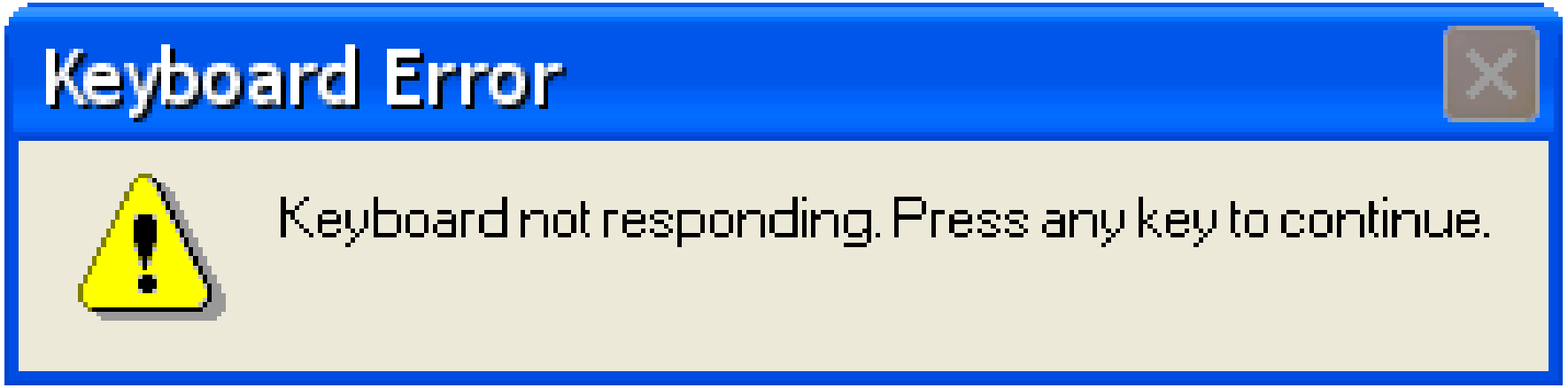

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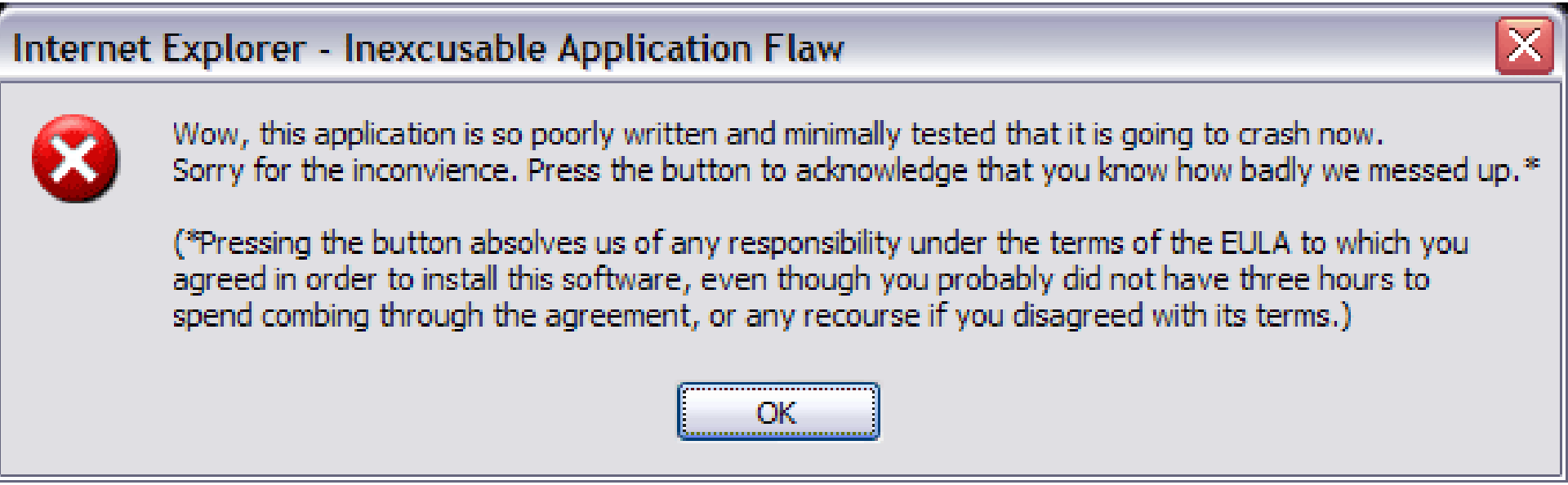


WHY EHRS FAIL

>System did not contain specialty-specific content

>System created prolonged threat to physicians' productivity

>System was missing critical modules

>Training time allocated by practice was insufficient

>Trainer was unqualified

WHY EHRS FAIL

>Implementation was flawed

>Practice did not commit proper resources/time to project

>Infrastructure, network and/or hardware were inadequate

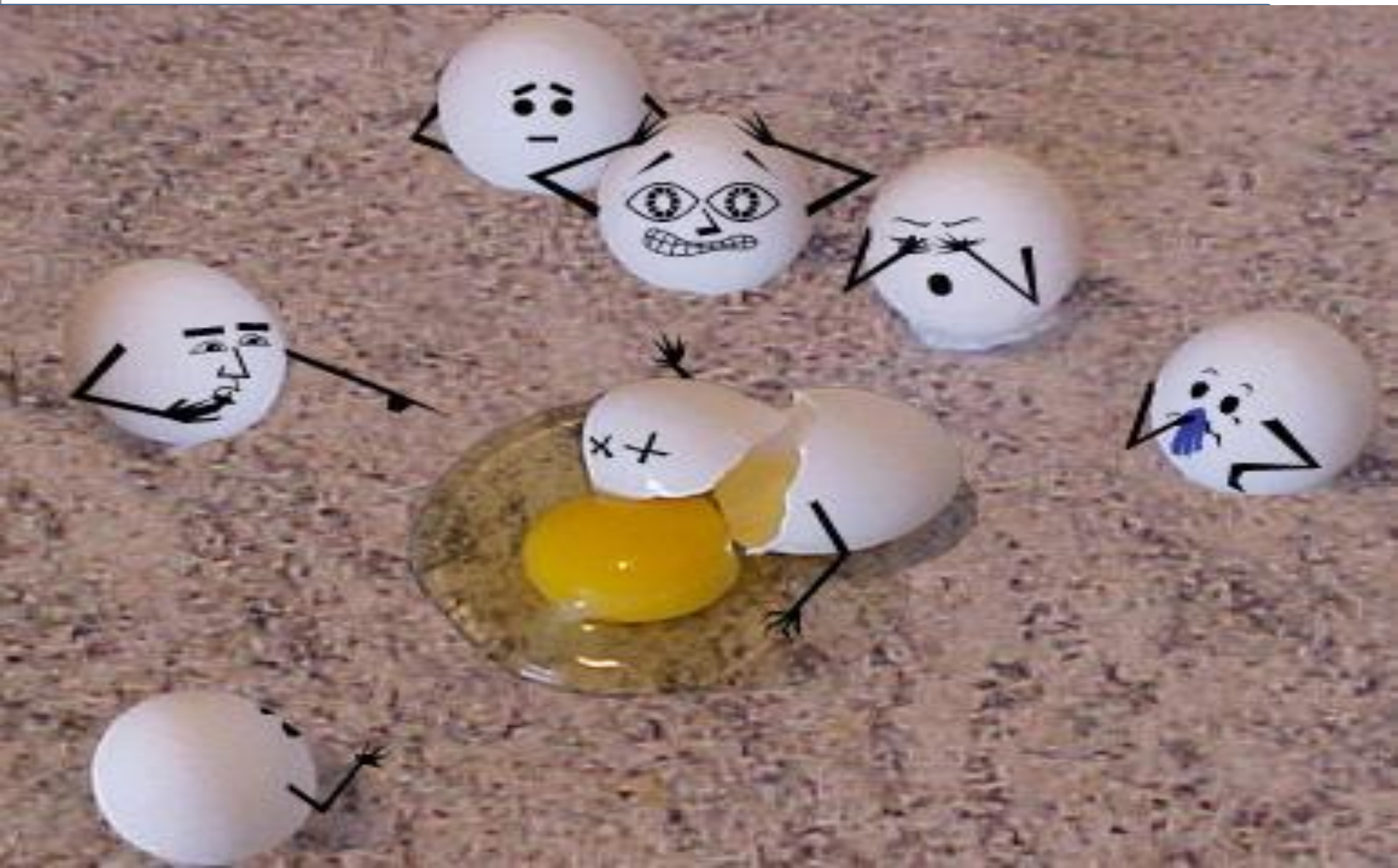
>Vendor over-promised and/or under delivered

>Vendor discontinued product or stopped supporting system

STRATEGIES

- Even if the vendor is at fault, it is *your* problem - - and it is a *serious* problem!
- Don't "attack" vendor as this will not enhance desire to resolve issues
- Present the facts, suggest some options, ask for their input—give them a deadline for resolution (stay firm, but professional)
- Ask for examples where the problem does not exist for other clients
- Engage experienced HIT consultant if necessary

Should You Replace Your EHR?



Should You Replace Your EHR?

1. Can the issues be resolved through remediation?

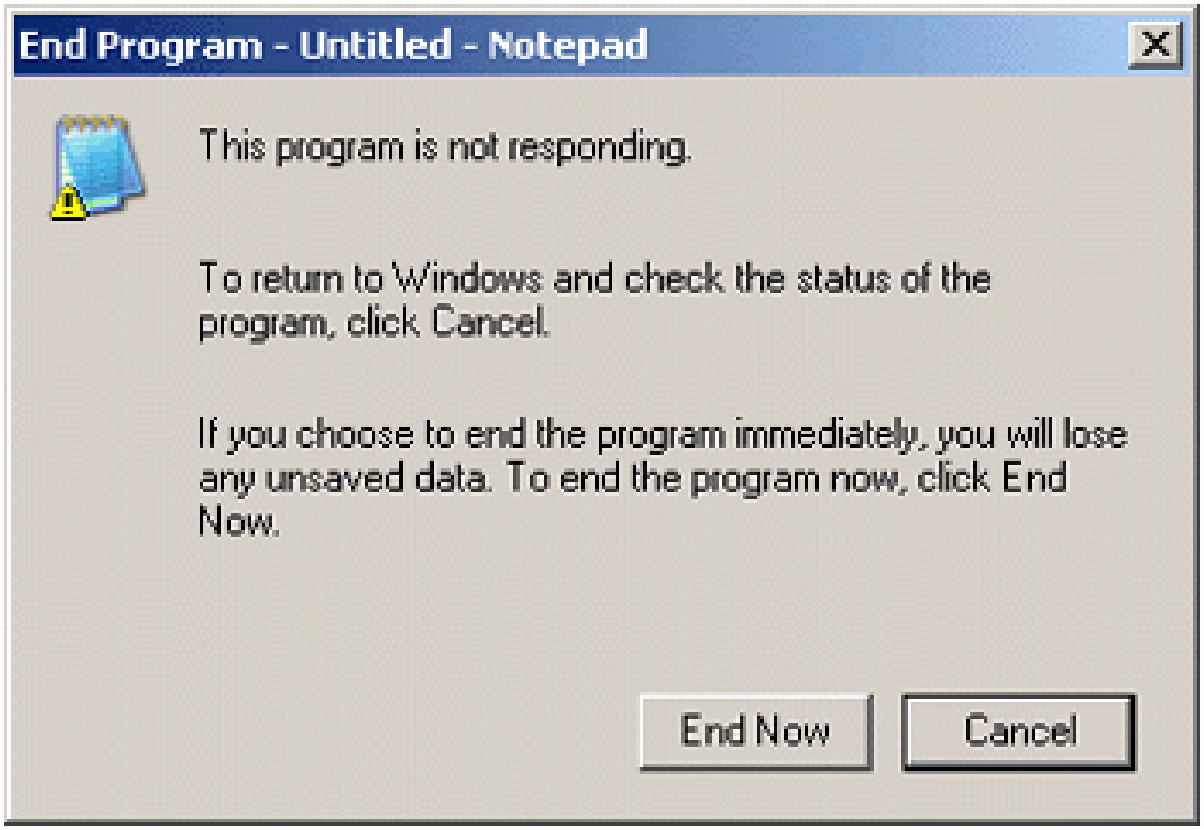
2. Can the issues be resolved with technical improvements?

3. Is vendor being responsive and concerned about the issues?

4. Does the practice bear some responsibility for the failure?

5. Has the product or version been commercially discontinued?

Steps to Move Forward



Not Responding is the WORSE decision a practice can make

Steps to Move Forward

- The last thing you want to do is deinstall a system that has practice/patient data
- Without proper planning, it can be very time-consuming and labor-intensive for the practice to switch systems
- Attempt to resolve issues
- When all efforts have failed - - follow the correct steps to prevent another failure

Steps to Move Forward - Analysis

- What is the cost to replace your system (EHR only or PM/EHR)?
- Review your contract to determine termination clause and any penalties
- Analyze 'soft' costs
  - Salary expenses related to deinstall process and time for training/implementation on new system
- Develop budget for *all* costs
  - New system, implementation, soft costs, etc.
  - New servers & equipment, if applicable

Steps to Move Forward - Analysis

- Conversions from one PM to another PM is more common and standard for vendors
- EHR conversions are more complicated due to the variances from one EHR to the another.
  - Could cause some unwanted liabilities
- Perform in-depth due diligence with proposed new vendor to determine ability to migrate EHR data, chart notes, documents, lab results, etc.
- Ask for migration references and get all details of EHR to EHR conversion in writing

Replacement or Reinvigorate

Replacement or Reinvigorate

- Replacing an EHR is a huge project; however, don't avoid doing so when it is the right thing to do
- If the vendor cannot perform or deliver service; or if their system cannot meet your practice's needs, then move forward, taking the right steps, to replace
- Any system not meeting certification or one that will be commercially discontinued, should be immediately replaced
- **DON'T BE AFRAID TO ASK FOR A REFUND!**
  - **Coker can been successful helping clients get refunds**

REINVIGORATE…

In some situations, the system does not need to be replaced—it must be optimized for the specialty or nuances of the practice

Do not try to fully customize all at one time

Start with basic system and determine which 2-3 “must haves” are essential

Add further enhancements after the initial ones are successfully deployed

Protecting Your Investment

How to Negotiate an IT Contract Like a Pro

There are TWO Important Factors to Successful Negotiations

1. Make the vendor aware that he has a credible competitor, but not who it is.
2. Identify all the costs and deliverables to negotiate.

What to Negotiate Over

- Initial costs
- Hardware cost
- Software cost
- Communications cost
- Installation cost
- Ongoing support cost
- Implementation cost
- Support cost
- Technical support cost
- Integration costs
- Interface cost
- Entitlement to new releases/bug fixes
- The cost of tailoring
- Future upgrades and releases (This should always be at no additional cost)

Modifying the Contract

- Source Code
- Acceptance Period (Hardware & Software)
- Implementation Caveats
- No Front Loading of Support Fees
- No Front Loading the Purchase Terms
- Assignment
- Future Upgrades and New Releases
- Copyright Infringements
- Warranties
- Termination
- Future Providers and Fees (Recurring cost)

Final Steps to Negotiation

- **Time is on your side so do not rush. You will have up to 10 years of regret for making a quick decision.**

KNOWLEDGE SHARING…

- Vendor Demonstration Tools
  - Score Cards
  - Demo Scenarios
  - Scribe my exam
- Sample RFPs
- Reference Check Tools
- Site Visit Tools
- Tools for Comparing cost, including recurring cost
- HCIT User Conferences/Summits/Forums
- NRHA Meetings and Webinars

Additional Resources

- Leverage your association
- Take advantage of attending conferences
- CCHIT.ORG
- HIMSS.ORG
- AAOE.ORG
- NRHA.ORG
- Network with other members
- FREE Contract Inspection – **jdaigrepont@cokergroup.com**

FINAL THOUGHT

FIVE STAGES OF

EHR ADOPTION

From *Death and Dying by* Elizabeth Kubler-Ross

1ST STAGE: DENIAL

- Occurs from time of purchase until first few days of go-live
- Sees only benefits of EMRs
- Denial of any difficulties

2ND STAGE: ANGER

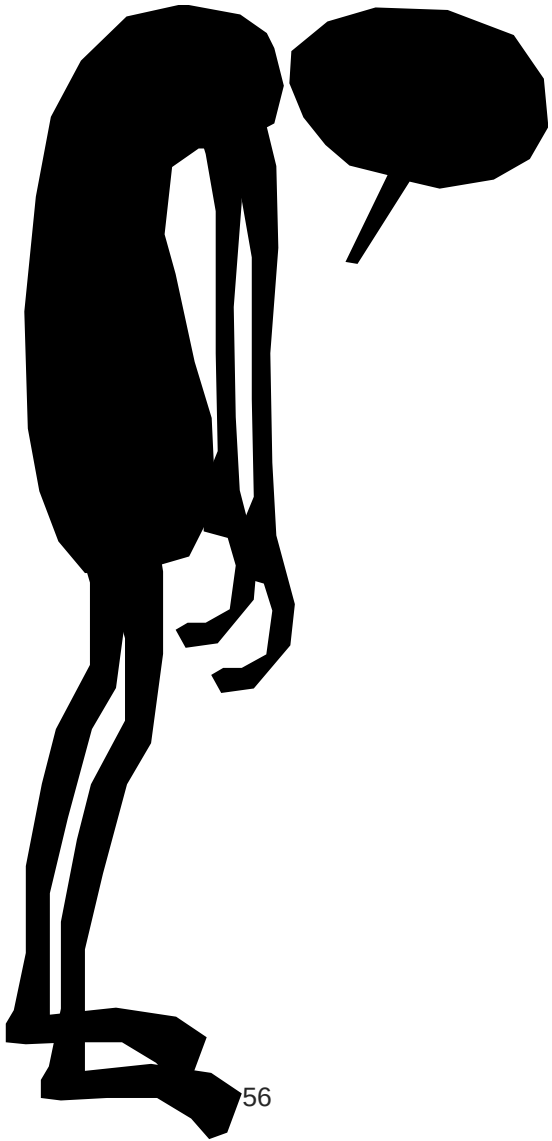
- Typically lasts one month
- Angry because of reduced patient volumes
- Staff upset with new system

3RD STAGE: BARGAINING

- Lasts 2-4 weeks
- Plead with vendor to make program work
- Will do anything

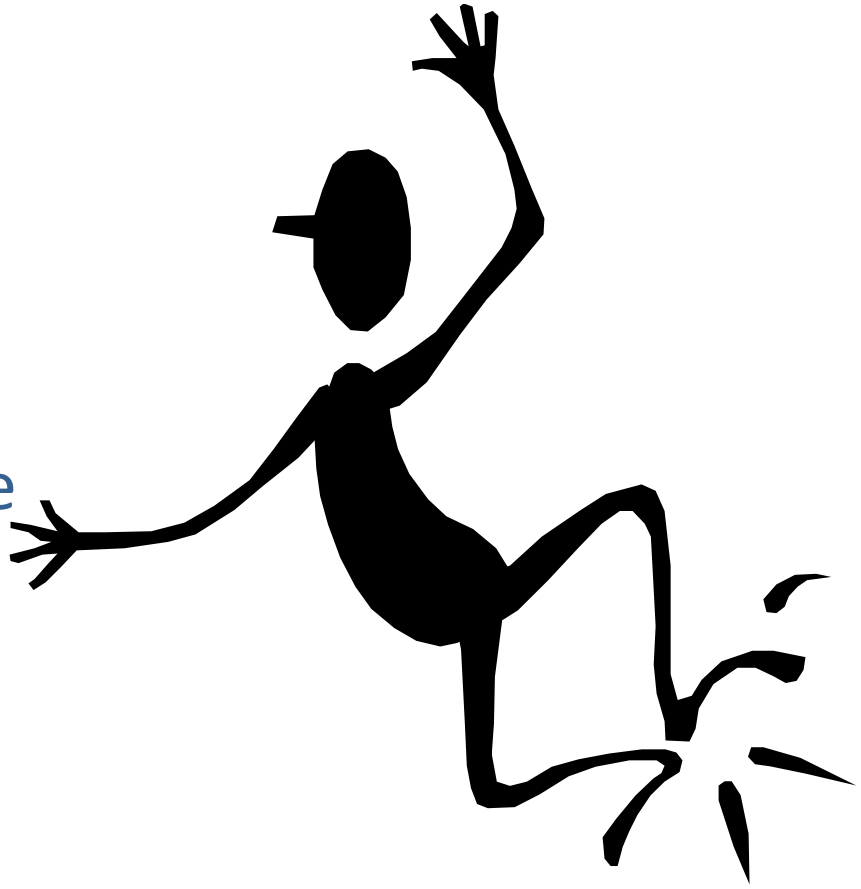
4TH STAGE: DEPRESSION

- Lasts 3-6 months
- Assume program will not work
- Can't abandon it since it costs so much



5TH STAGE: ACCEPTANCE

- It all starts to fall into place
- See benefits from the system
- You and every one else live happily ever after!
- Cause for celebration



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Business Advisors for the Healthcare Industry

Thank You!

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