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Gatefold

IT Challenges in Physician Practice Management

Fully functional EMRs can improve care delivery and increase efficiency. Yet, barriers to adoption remain—particularly when it comes to connecting hospitals with physician practices.

The electronic medical record will play a central role as health care is reshaped to meet reform and market demands. Fully functional EMRs can improve care delivery and increase efficiency. Yet, barriers to adoption remain—particularly when it comes to connecting hospitals with physician practices.

"The thought from policymakers was that by easing up on Stark and the antikickback statutes there would be a swarm of hospitals handing out EMRs like Halloween candy," says Rob Tennant, senior policy adviser for the Medical Group Management Association. "That didn't happen." Some hospitals, he says, are still concerned about the legal implications of helping physician practices set up EMRs. And the expense of doing so, as well as resource constraints, are still very prevalent.

The American Recovery and Reinvestment Act of 2009 allots funds to hospitals and physician practices that adopt EMRs, so long as they can demonstrate meaningful use of the technology. While "meaningful use" has yet to be fully defined by the federal government, it is clear that eligible hospitals and other providers must use a certified EMR with e-prescribing, submit quality reporting and participate in the electronic exchange of health information. Physicians can receive up to \$44,000, with as many as five payments for early adopters.

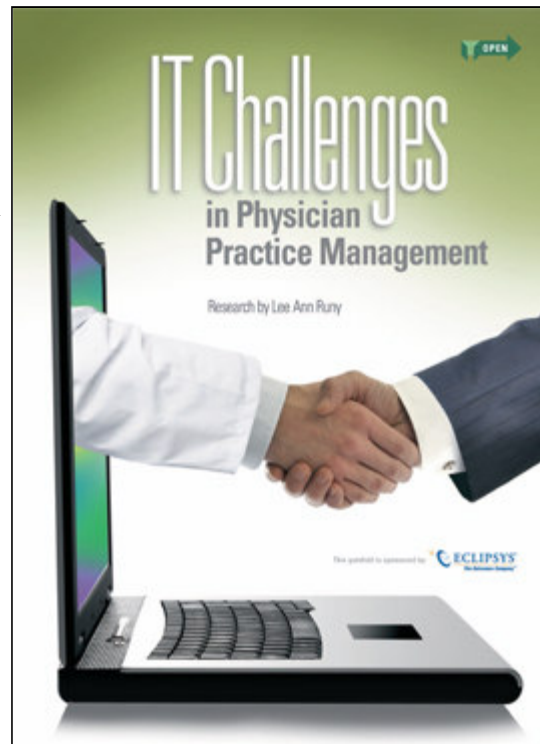
Hospitals can receive between \$5 million and \$10 million, with up to four payments for early adopters. But with an initial reporting date of Jan. 1, 2010, few hospitals will be ready in time to take advantage of the full incentive. Moreover, says Tennant, compliance standards are too onerous, making it difficult for many providers to qualify for the payments.

Hospitals face a number of barriers beyond financial concerns in trying to connect with physician offices.

"Hospitals need time, money and staff to help physician offices adopt IT," says Edna Boone, senior director of health care information systems for the Healthcare Information Management Systems Society. Many hospitals, she says, don't have a deep enough IT staff to assist physician practices with the implementation and ongoing maintenance of EMRs.

Buy-in from physicians and their office staffs is another roadblock. Physician practices frequently are not technologically advanced and the doctors and their staff members may resist changes in workflow brought on by EMR adoption. "We have not engaged the office staff enough," Boone says. "Quite often, the focus has been on the physicians. But it's the other folks who will be doing the heavy lifting."

Hospitals that are considering connecting with physician practices should set realistic expectations for the project. "It's important that the physician practice is engaged and that an adequate support structure for pre- and post-implementation is in place," Boone says.



EIGHT STAGE EMR adoption model

The electronic medical record adoption model outlines stages of EMR development, providing a methodology for evaluating the process and impact of EMR

STAGE	CUMULATIVE CAPABILITIES
Stage 7	Full electronic medical record, health care organization able to contribute continuity of care document as a byproduct of the EMR; data warehousing in use
Stage 6	Physician documentation (structural templates), full clinical decision support system (variance and compliance), full radiology picture archiving and communications system
Stage 5	Closed loop medication administration
Stage 4	Computerized provider order entry, clinical decision support system (clinical protocols)
Stage 3	Clinical documentation, clinical decision support system (error checking), PACS available outside radiology
Stage 2	Clinical data repository, controlled medical vocabulary, clinical data support system, may have document imaging
Stage 1	Ancillaries all installed
Stage 0	All three ancillaries—lab, radiology, pharmacy—not installed

Source: HIMSS Analytics, 2008

Physician-office EMR functionalities

Percentage of physician practices in which the following physician-office EMR functionalities are implemented

Employed physician practices	
Results viewing	63%
Electronic clinical documentation	45
Computerized provider order entry	36
Decision support.....	36
Independent physician practices	
Results viewing	49%
Electronic clinical documentation	28
Decision support.....	22
Computerized provider order entry	20

Source: Hospitals & Health Networks' Most Wired Survey and Benchmarking Study, 2009

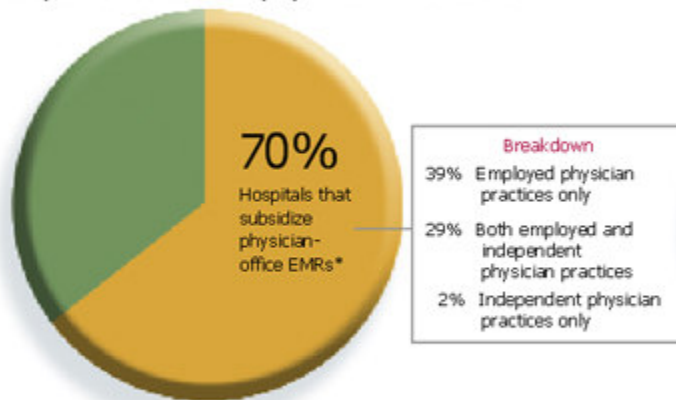
EMR component utilization rates

What types of components are being used

Component	
Physician charting/documentation	75%
Nursing charting/documentation	74
Appointment/patient scheduling.....	66
Physician order entry with clinical decision support with all orders.....	61
Physician orders—meds and refills only	60
Nursing orders—meds and refills only	58
Reference lab connectivity for orders/results	55
Nursing order entry with full clinical decision support	54
Imaging connectivity for studies, results, PACS viewing	52
Patient self-reporting and messaging	31
Online consultation	21

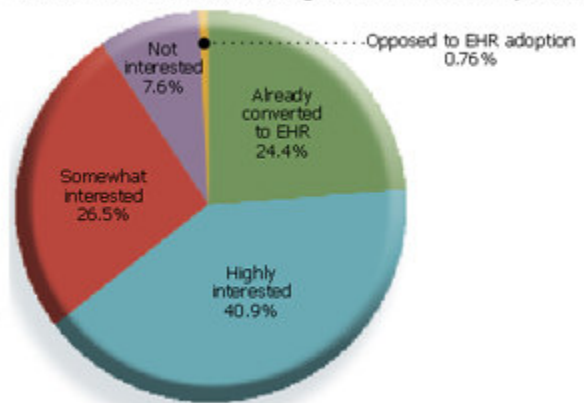
Source: HIMSS/HIMSS Analytics Ambulatory Healthcare IT Survey, 2008

Hospital subsidies for physician-office EMRs



*Percentage reflects all respondents to the 2009 Hospitals & Health Networks' Most Wired Survey and Benchmarking Study.
Source: Hospitals & Health Networks' Most Wired Survey and Benchmarking Study, 2009

Physicians want electronic health records Level of interest in converting to an EHR at their practice



Source: MGMA Pulse Check, 2007

FOUR LEVELS of hospital-physician practice EMR interoperability

The level of connectivity between a hospital and physician practice will vary depending on the relationship model. Hospital officials need to determine which level of interoperability to provide based on that relationship. Levels of interoperability include:

LEVEL
IV

Interoperability

Interoperability occurs when the hospital and physician practice are able to share data through their separate EMRs. True interoperability often requires a single-vendor solution.

LEVEL
III

Single sign-on

Similar to view-only access, single sign-on additionally provides an alert function to the physician when a patient is admitted to the hospital and provides some interoperability. The physician practice may need technology that can accept data in a specific format from the hospital information system.

LEVEL
II

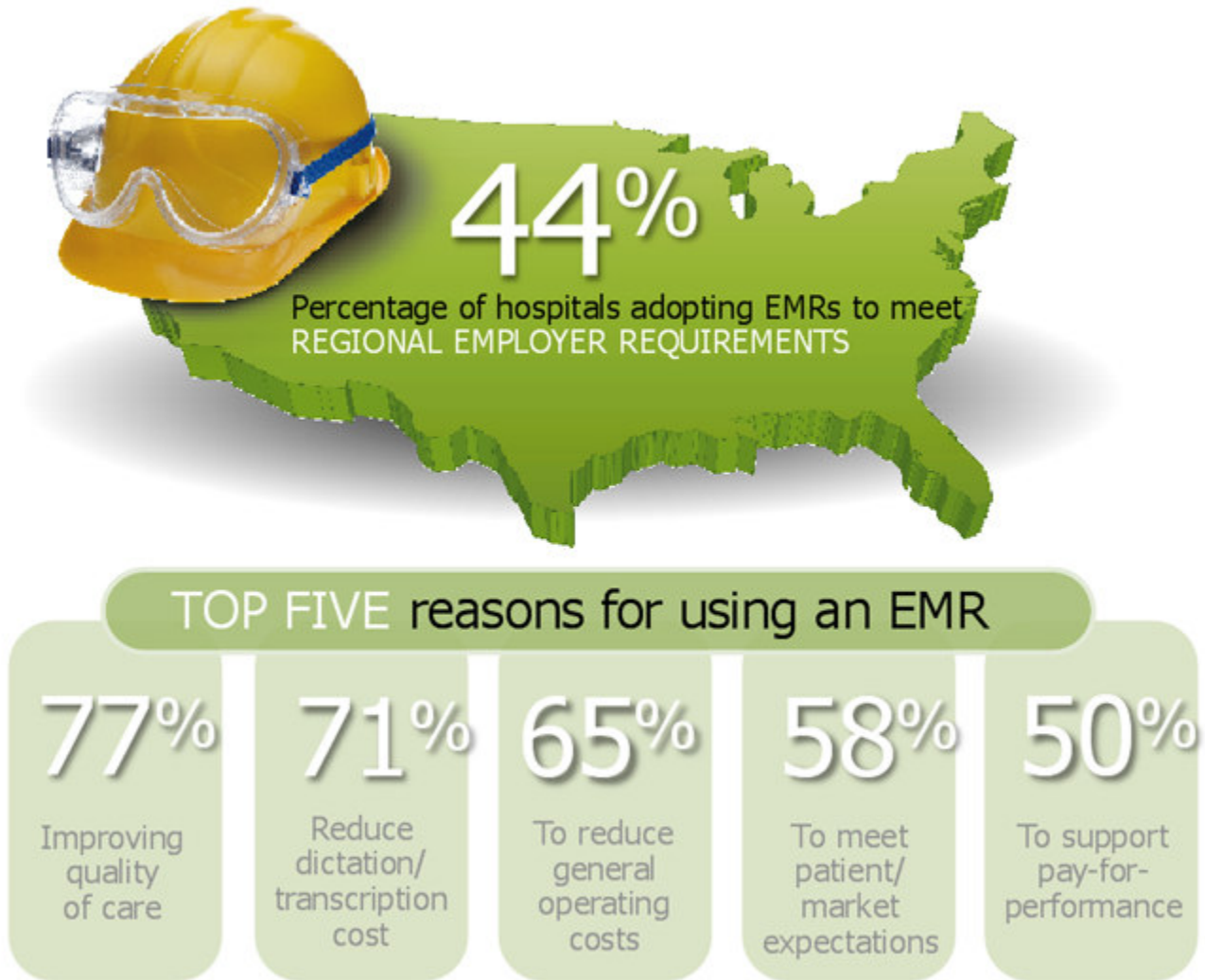
View-only access

Physicians access patient information via a Web interface. Physicians can access one patient record at a time. This type of access usually requires the physician practice to purchase new software.

LEVEL
I

Direct access

Physicians are given full access to the electronic medical record. This level of access typically does not require new technology or interfaces.



FIVE BARRIERS to EMR adoption

Despite known benefits, barriers remain that prevent or delay EMR adoption. Cost is one of the biggest challenges, putting EMR implementation out of reach for some hospitals and physician practices.

1

COST

Cost remains a significant obstacle to EMR adoption by hospitals and physician practices. The recession has further restricted access to capital, forcing the postponement or cancellation of capital projects.

2

SUPPORT

While acceptance is growing, many physicians perceive that EMRs will take away their autonomy and increase their workload.

3

EMR MAKEUP

Independent physician practices often seek customizable EMR solutions from hospitals to more closely reflect their practice. Customized solutions are more difficult for hospitals to oversee and maintain.

4

INTEROPERABILITY

EMRs already adopted by physician practices are often incompatible with hospital systems or require expensive interface solutions.

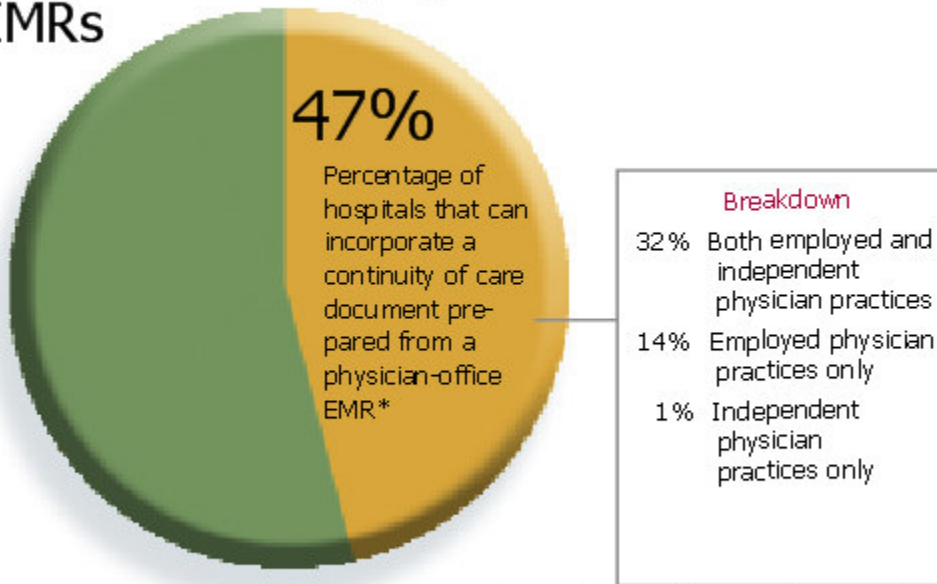
5

IMPLEMENTATION

Resources are limited for implementation, training and ongoing maintenance of the EMR. Physician office staff may not have the technical savvy to implement and oversee EMR usage. Hospital IT departments may be stretched thin by the training needs of physicians and their office staff, and by ongoing maintenance and system upgrades.

Source: H&HN research, 2009

Ability to accept continuity of care document from physician-office EMRs



*Percentage reflects all respondents to the 2009 Hospitals & Health Networks' Most Wired Survey and Benchmarking Study.
Source: Hospitals & Health Networks' Most Wired Survey and Benchmarking Study, 2009

Case Studies

University Health System, San Antonio

University Health System operates under a closed physician model with a fully operational EMR. Ninety-nine percent of all orders are placed electronically. "We are using the EMR to its fullest," says Bill Phillips, chief information officer. The organization started with a light rollout of the EMR in 2005 and finished with a more aggressive rollout in 2006. "Regardless of whether you have an open or closed physician model, you will face the same challenges," Phillips says. Workflow will change significantly, he says, adding, "Paper doesn't convert to the electronic environment. That's huge." And hospitals will face pushback from physicians regardless of their affiliation. At University Health System, ambulatory physicians resisted a requirement that they enter their own orders, an issue that still comes up periodically. But the organization has had success in part because of its openness with physicians. "We were very up front with the physicians," Phillips says. "We told them they would lose productivity. We recommended that the clinics reduce their volume initially and gradually build it back up." Today, physicians depend on the system. "They see the value," he says. "They are more engaged and they recommend ways to make it better. It has helped enhance our core outcomes."

NorthShore University HealthSystem, Evanston, Ill.

Since its inception, NorthShore University HealthSystem has committed to making the EMR mandatory for both its employed and independent physicians. The organization initiated a rapid rollout of its EMR to its employed physician group in 2003 and its independent physicians in 2004. Employed physicians were provided a standardized product that mirrored the inpatient EMR. Independent physicians were able to customize the EMR to fit their practice needs. "We've spent much more time on the independent practices," says Tom Smith, CIO. The employed physicians made big decisions as a group up front, he says, while the independent physician practices made decisions on a case-by-case basis, often needing approval from several physicians in the practice. "We are about to announce a new rollout for physicians who want to take part in the stimulus," Smith said in October. "This time we'll take a more standardized approach. We cannot give too much flexibility. We've learned a lot over time." A big concern for the independent physician practices was ownership of financial data. NorthShore developed a solution that separates financial data from clinical data. "They wanted to be sure the information wouldn't be shared," Smith says.