

## **HHS Panel 4: Experience from the Field Experience of Primary Care Physicians In Implementing Meaningful Use in the Field**

Presenters: Jacqueline W. Fincher, MD, MACP  
Managing Partner, McDuffie Medical Associates  
Thomson, GA

Pam Shivers, BS, CPC  
Practice Administrator, McDuffie Medical Associates  
Thomson, GA

### **Introduction/Background:**

McDuffie Medical Associates in rural East Georgia is a 4 physician primary care private practice with two Internal Medicine Physicians and two Family Physicians. The average age of the physicians is 50 years old. There are no physician extenders employed. We employ six LPNs, three medical assistants, four front office/administrative personnel, and one practice administrator, average age is ~ 42 years old. The population of the McDuffie County is ~ 21,000, on the cusp of a large rural area (~ 75,000) before it feeds into Augusta, GA ~ 35 miles away.

Our office demographics by payor include ~ 40% Medicare, <5% Medicaid, Tricare 5%, 40% private insurance and 10% uninsured. The average income of our two Internists is \$130,000, while the average income of our two FPs is \$170,000, the difference being the volume of patients each can see.

**EHR Selection/Implementation:** In 2004, we made a decision to go to an electronic health record. We were the first practice in our community to implement an EHR and tried very hard to get other practices to work together on this project to no avail. Three of the other seven practices in our town have since each installed and implemented a different EHR in the last three years. Our local 25 bed hospital has just implemented another completely different EHR. None of the practices interface with one another or our local hospital due to poor communication, cooperation, and interface costs.

Our practice in 2004, took almost two years to research different EHRs which included our own personal networking with other practices within the state of Georgia and going to the American College of Physicians and American Academy of Family Physicians national meetings, where we visited EHR vendors and took courses on electronic health records. Over the two year period, we narrowed the choices to five vendors who did

demonstrations at our office. We then narrowed it to three vendors and did site visits to physician offices with the three different EHRs. We then narrowed it to two vendors and who could give us the best deal and interface with our existing practice management system.

We made our decision and set up an implementation schedule over six months to meet benchmarks of progression to our “go live” date June, 2006. These six months included multiple meetings weekly with some or all of our staff and multiple days of off site training for six appointed “super users” from our staff. We had to locate qualified IT personnel in Augusta to help us. We had to reconfigure and rewire our building and treatment rooms. We had to put in a whole new air conditioning unit/system for the new large computer server. We took a \$200,000 loan out for the hardware, software, and the building adjustments. ROI was estimated at four years. It took five years; we have just completed paying off the loan.

From the “Go Live” date in June 2006, there was an absolute requirement to drop patient volume by half for the first three months. This was done by design during our slower summer months. The learning curve to take our middle age practice from paper to electronic records was truly exponential. We honestly have never gone back to the previous volume of patients, but with the EHR our charts are far better organized and documented resulting in more appropriate coding for the level of work being done, especially on complicated Medicare patients.

We know we are better physicians now because we can measure it. We know we have made huge improvements in hypertension control, diabetes control (with improved HgbA1Cs, eye exams, and foot exams), and cholesterol control. We know we have done a much better job preventive health maintenance areas including PAP tests, mammograms, colorectal screening, and immunizations because we established a baseline in 2006, and we measure it quarterly. These reports are sent through our EHR to the Medical Quality Improvement Consortium (MQIC). Many EHR products do not have this capability within their own systems. We also report our measures to each physician individually and collectively in addition to our nursing staff, which forces us as clinical teams to focus on key areas that may not be at the determined threshold goals.

We know we are now doing a significantly better job of taking care of our patients, because the whole team is involved and the EHR allows us not only to establish a high standard of care but actually maintain it. This has all come at a significant price. Despite significant increases in our cost of doing business every year, in addition to the cost of the EHR, our

reimbursement and salaries have remained flat in a world that has had significant increases in the cost of living and the cost of doing business over the same ten years.

I say all of the above to emphasize the huge very tedious investment of time, money and effort it requires to take a small practice office from the paper world to a digital world, and now to a world of “Meaningful Use Stages 1, 2, 3.” Just to prepare to meet Stage I of Meaningful Use for our practice that has had a top tier EHR in place for 5 years is a very challenging task. As I look at the landscape of small group private practices especially primary care practices, I remain very concerned for those who are just beginning to select and implement an EHR. With the current time table for MU Stage 1 and its now 20 month deadline to obtain the initial and largest amount of MU money, I seriously doubt that many of these small practices will be successful. Small group private primary care practices have the most skin in the game, the largest percentage cost to them personally, the greatest responsibility for patients, the highest risk of failure of implementation, with the least amount of resources and support. Understandably the RECs have been put in place to mitigate these many of these issues, but they appear to be overwhelmed and limited in their scope of help.

**Applying for Meaningful Use:**

We are planning to apply for reimbursement for Meaningful Use of HIT via Medicare in the Fall of 2011. In order to accomplish this, our EHR vendor was given only six months from the time the Stage 1 MU requirements were published to meet the criteria in order for us to even consider the first reporting period this spring. We needed time to get our own financing worked out, get out of the late flu season, and get on the vendor’s schedule. Our vendor, considered one of the top tier systems, has been working diligently with us to get our practice ready for the major upgrade to their MU Certified version. We have been preparing since January. The upgrade alone is costing us \$75,000, in addition to five full days of hourly work in the office to complete it – two of which were business days requiring the whole office to be shut down. The major portion of this was supposed to be completed this past weekend and it has NOT gone smoothly. The problems have clearly been on the vendor side. Our vendor is currently doing major upgrades with their current EHR clients to their MU Certified versions three of four weekends of every month. They are being pushed hard and we are seeing some of the fallout. It has been a difficult week to say the least. It appears practices just serve as a conduit for MU dollars to flow to EHR vendors with the initial impact on our cash flow first.

**Core Objective Requirements:**

Clearly the core objectives create the greatest burden of responsibility on primary care physicians, as we can not say “not applicable” like many subspecialists will attest. We as primary care physicians continue to carry the greatest burden and responsibility for patients and are expected to deliver all this coordinated care in a 15 min visit. MU requirements for specialists should not maintain their silos with all the responsibility on primary care physicians to do all the coordination of care. We strongly recommend specialist objectives that demand and prioritize timely electronic communication and coordination with primary care physicians.

Over the past five years of using our current version of EHR, the “core objectives” that are more easily attained include the patient demographics, active problem list, medication list, and allergy list that are all standard in most EHRs. The recording of smoking status is easy to implement and probably should be listed as a sixth vital sign. Through the e-prescribing component of our EHR the drug-drug and drug-allergy interaction checks are simple and automatic.

Transmission of prescriptions electronically has brought its own unintended consequences, (for instance, patients calling for their refills on a prescription number that has no refills left, but no acknowledgment from the pharmacy that a new prescription is already on file, pharmacies automatically refilling prescriptions that have been discontinued.) Patients frequently request that prescriptions not be sent electronically because the pharmacy automatically fills them that day when the patient may not need it for several weeks. The state and federal laws lag behind the technology when it comes to prescriptions for Schedule 2 drugs. Many mail order pharmacies do not accept prescriptions electronically, only by fax. We have major concern here about the current thresholds of numerators and denominators in Stage 1 and then increased in Stage 2, and what mechanisms actually work best for the patient to obtain their prescriptions.

Reporting of quality measures (CQMs) is very challenging in the beginning stage. We submitted PQRI measures to CMS in the first year of eligibility. It was quite cumbersome to get the workflow down, and it was initially done on paper and transcribed into a computer program. After the MQIC program became available, our quality measure data was extracted directly from our EHR system, which made it immensely easier and we qualified for the PQRI bonus in the first year. We are also concerned about the correlation of CQMs with other current available programs. These need to be aligned. The reality of being able to meet the CQMs for most primary care offices within the next 18 months will be very challenging when they are trying to do so many other workflow changes to the office.

After having five years of EHR experience, the additional core objectives that represent the greatest challenges are the ones that “engage patients and families in their health care.” Huge variations of culture, education, literacy, etc make this area exceedingly difficult, especially in our poor rural area. Providing patients with an electronic copy of their health information within three business days is relatively easy with use of CDs or flash drives, but has been minimally requested or used by our approximately 10,000 patients. While providing clinical summaries to pts for each office visit is ideal, it is difficult, particularly at the time of the visit. In a busy primary care practice that deals with large volumes of patients daily, it is very difficult to complete the impression and plan for each patient at the completion of the visit. Labs have to be ordered, referrals made, records obtained, etc. It is not clear weather the clinical summary must be given to the patient directly or if it could be obtained through the patient portal. Mailing or emailing the next day or so just creates yet another cumbersome workflow step requiring staff time, effort, and organization. The reality is in our area of 50% illiteracy, low education, and a rapidly aging population all of these written summaries will only be used by a few.

Finally exchanging key clinical information from individual private practice physicians to other providers electronically remains a major problem for which the individual physician has little control. Until and unless EHRs are fully integrated and interfaced on an electronic highway, this objective will be limited and piecemeal at best in the private practice world or until we are all integrated into large health care systems on an enterprise wide system. We are clearly not there yet.

**Menu Objective Requirements:**

Generating list of patients by specific conditions and giving patients education resources are on the short list of easy menu objectives and are basic to most EHRs. Many of the other menu objectives clearly are more challenging and raise the bar. Again the issue is here is how can an individual physician meet many of these objectives that are dependent on other providers, agencies, public health and government entities to be able to accept electronic submissions? Drug formulary checks are helpful for the patients whose formularies are registered, but many are not available. Incorporating lab results as structured data is wonderful if there is an interface with the lab and they have paid for it. Many rural physicians just work with their small hospital labs, neither of which can afford the interface. As a result all labs come in as faxes and must be put into flowsheets manually by clinical staff.

Patient reminders and the installation of a patient portal are clearly more challenging and costly objectives. It would be easy to send a reminder

through a patient portal provided secured messaging is used but using a patient portal is also VERY costly. The cost is not only for maintaining the portal, but there are additional costs for the server and secured messaging (i.e., every component of the PP costs more money). There are so few vendors offering a patient portal product at this time which also drives the cost. A recent quote to our practice from one of the two major vendors was \$130-150 per provider per month for the basic model. If you don't have a patient portal then sending a reminder through the mail is also costly in staff time and postage.

Medication reconciliation for transitions of care needs further definition in order to fulfill a 50% threshold. We agree that clinical care summaries (CCS) for transitions of care are critical but there needs to be some standardization of what components should be a part of a CCS. Vendors each have to write new forms for this requirement. Our vendor has not completed a new form for us at this time.

**Conclusion:**

Our practice is a huge proponent of EHRs as evidenced by our early adoption and frequent educational presentations we have made at numerous state and national meetings on the essential keys to successful EHR selection and implementation. These are huge undertakings for any practice. They require enormous amounts of time, energy, IT expertise, coordination with vendors, and other entities in the health care enterprise, not to mention tremendous amounts of capital to make it happen. Most practices can not afford any major mistakes. Meeting Stage I Meaningful Use requirements for most small private primary care offices is like doing a major renovation and construction in your kitchen and still having to provide three meals a day and snacks for a large extended family. You are glad when it is done, but it is pure hell going through it.

We want to see small group practices be successful in this endeavor. The timeline to meet Stage I MU requirements and receive the incentive money for most small group practices that are now just selecting and beginning implementation of an EHR is daunting. I fear the majority will NOT meet the objectives by December, 2012 and will feel duped by all involved. A major challenge for all practices seems to be aligning physician and vendor time-lines for final decision making, training and implementation and affording the direct and indirect costs that go with it. The other major challenges to Stage I MU are the requirements that are dependent on other health care entities to exchange electronic information for which the individual physician will have no control.