After five years of struggling to make your Electronic Health Record (EHR) system work, you’ve hit a brick wall. You’ve tweaked, trained and customized to no avail. The system simply doesn’t meet the needs of your practice. Worse, your implementation budget has been burned through.

Communication with your EHR vendor has broken down, and your calls and support tickets go unanswered. With providers and staff so frustrated, the idea of scrapping your system is gaining traction — despite the inevitable financial hit and challenges of starting over with a new EHR system.

Unfortunately, more and more physicians are finding themselves holding their last straw with their EHR systems. In fact, technology market research firm Black Box is calling it the “Great EHR Switch.” In a survey of nearly 17,000 active EHR users last year, the company found that 23 percent of those surveyed said they were planning to switch EHR vendors, and a full 8 percent wanted to switch but couldn’t afford to make the move.

Topping the list of reasons for dissatisfaction was unmet expectations — EHR systems simply were not meeting the unique needs of the practice. Interestingly, respondents didn’t put all the blame on their EHR vendors — a whopping 79 percent admitted that they had not adequately assessed their needs before making their EHR purchase.

Breaking Up Is Hard to Do
Of course, your EHR contract includes a warranty that addresses defects in the software, and many also include a “failed implementation” clause that spells out remedies if the vendor cannot successfully implement the system. But the reality is that, despite their best efforts, EHR vendors sometimes can’t fix the problem because the software simply doesn’t match your practice workflow.

The good news is that there are plenty of EHR systems available on the market today. It may be easier to find one that better matches your clinical workflow than sticking with an inefficient system. And breaking up with your EHR vendor doesn’t have to be an ordeal. As with most things, the key is clear and open communication. Consider these five steps:

**Step 1: Get everyone on board.**
Ensure buy-in from key players in the practice. Make sure everyone understands what is going on and why it is happening — from physician owners and organizational leaders to clinicians and other staff. If you meet resistance, thoroughly outline the problems the current system is causing and their resulting impact on the practice.

**Step 2: Review your contract.**
Go through your EHR contract line by line. Were you guaranteed certain services that were not delivered? Are there any restrictions or termination penalties written into the contract? There will no doubt be plenty of fine print, so consider having the contract reviewed by an attorney with experience in the healthcare IT field.

**Step 3: Look inward.**
Spend some time evaluating what went wrong in the last selection. Any EHR switchover is pointless if you don’t address the root causes of the initial failure. Was the problem with implementation? Was it an organizational issue? Was there a snag with the software? Or, more typical, were the challenges more of the human variety, such as getting buy-in from a few foot-dragging providers?

**Step 4: Start the search.**
Before contacting your current EHR vendor, get all your ducks in a row by researching some new EHR choices. Yes, you’ll basically be starting over from the beginning — but this time, you’ll hopefully know exactly what will work for your practice. Collect pricing information and options. And ask any new vendors for the names of 5-10 of their clients who match your practice’s specialty, size and workflow — and then contact a few.
Extricating Yourself From a Bad EHR Contract, cont’d.

Step 5: Contact your current vendor.
Here’s where it may get a little dicey. You’ll need to let your vendor know in no uncertain terms that you wish to switch to another vendor. A key point of discussion will need to be the handling of your “legacy data” (see the sidebar above for options on transferring practice data from one EHR system to another).

Discuss any penalties involved in terminating the relationship and document everything. Software provider SRSsoft suggests on its EHR & EMR Insights blog that practices can sometimes negotiate an addendum to the current contract waiving the termination penalty in return for a non-disclosure agreement (for example, agreeing not to bad mouth the current vendor’s product to peers).

Seize the Moment
The right EHR system can substantially improve practice workflow and productivity while enhancing patient care. And now may be the time to take advantage of innovation in the market. Mergers and acquisitions are creating powerhouse EHR providers, and new vendors are introducing improved EHR technology, including systems that utilize cloud-based technology that can be used from a variety of devices.

EHR implementation is a major undertaking for any practice. Mueller Prost can provide the guidance you need. Call your advisor today at 314.862.2070.
EMPLOYED PHYSICIANS: Is the Grass Really Greener?

This article is the second in a series exploring alternatives to the traditional private practice.

At some point in their careers, most physicians in private practice will ponder becoming an employed physician with a hospital or health system.

In fact, a recent survey by the Medical Group Management Association shows a nearly 75 percent increase in the number of active doctors employed by hospitals since 2000.

Who Wins What?

Make no mistake, hospitals benefit from these acquisitions. More doctors means more negotiating power with managed care contracts, as well as a boost in Medicare and other government payments.

For doctors, hospital employment provides everything from management and billing expertise to cutting-edge information technology. Physicians can also tap into a hospital’s often substantial inpatient and outpatient facilities, as well as a larger referral and coverage network.

But, as with most things, there are both pros and cons to making the leap from private practice to a hospital or health system:

**Good News:** Earning power can be greater. Contrary to popular belief, physicians who become hospital employees can enjoy higher earning potential than those in private practice — especially when factoring out malpractice costs, health insurance, overhead and other operating expenses. Certain specialties are decidedly in the driver’s seat.

Among employed physician specialties, these five stand out, according to Mercer’s Highly Compensated Physician Survey: noninvasive cardiology, ophthalmology, general orthopedic surgery, neonatal medicine pediatrics and neurosurgery.

Hospital-affiliated primary care physicians are also primed for higher pay, given the value placed on primary care under healthcare reform.

**Bad News:** Nothing is forever. That isn’t to say solid salaries are a given. In an article that appeared in The New England Journal of Medicine, Dr. Robert Kocher and Nikhil R. Sahni, B.S. note that in the future, physicians should anticipate a shift from guaranteed salaries to more incentive-driven compensation linked to productivity and clinical behavior. While base compensation may be lower than their previous earnings, incentives can increase compensation to that level or higher. Likewise, hospitals aren’t always a sure bet. Typical employment contracts last for three or four years, but they may allow either party to terminate the pact with six months’ notice.

**Good News:** With employment comes new freedoms. Employed physicians enjoy flexibility and freedoms not available in private practice. In particular, the newest generation of doctors seem to be attracted by the promise of a better work/life balance offered by hospital employment — and are willing to trade higher incomes for lifestyle flexibility and administrative simplicity.

**Bad News:** You will be managed. With more emphasis on quality improvement and measurement, employed physicians must not only take good care of their patients, but they must also meet certain quality scores and performance metrics. In addition to a loss of clinical autonomy, employed physicians may also discover that their new employer has taken control of their former business functions — everything from physician billing and collections to how the phones are answered.

In the end, understanding the issues and economics of hospital employment can help physicians make wise choices.

**Questions to Answer**

Before you make any decision, ask yourself the following questions:

- **“How much control do I want?”** Will you be satisfied as an employee of a hospital? This new role may mean no hiring power and limited autonomy over the direction your practice takes. Are you interested in an arrangement where you have a seat on a governing board, giving you some degree of control?

- **“How much flexibility do I need?”** If you’re not certain, give yourself an out. Structure the deal to include an opt-out provision that allows you to return to private practice after a stated period if you find hospital life isn’t working out. Likewise, seek flexibility in changing payment terms and other features.

- **“How much salary do I require?”** Typically, take-home salary remains roughly the same or better, with one critical caveat: Hospital-owned groups often experience substantial cash-flow issues in their first year. Basically, they are starting with zero accounts receivable. Here, a transitional salary can help smooth out the peaks and valleys of first-year cash flow — especially if you are uncertain about how incentives or productivity payment models will work out.

Mueller Prost’s experienced professionals can help you “run the numbers” to determine if hospital employment makes sense for you. Give us a call 314.862.2070.
Life After ICD-10

Most people don’t like change. And the switch to ICD-10 is about as big as change gets for practices. The new code set includes five times as many codes, and the different coding arrangements will certainly require more precise and thorough documentation.

In fact, a study commissioned by The American Academy of Orthopaedic Surgeons projects that the move to ICD-10 will increase documentation activities by about 15 to 20 percent. This translates into a permanent increase of 3 to 4 percent of physician time spent on documentation.

That said, the new code set does offer real value to physicians who leverage it correctly.

- **Potential for increased compensation and reimbursement** – ICD-10 provides more diagnostic choices, and the codes carry much more descriptive information. In particular, the new code set offers a better way of documenting “severity of illness.” Physicians can use ICD-10 to make sure that charts reflect how sick patients really are. By providing greater detail on the severity of the illness and the quality of the care they provide, physicians can help ensure that they are fairly compensated for the complex work they perform.

- **Faster payment** – The specific codes of ICD-10 may also simplify prior authorizations or eliminate the need for an appeal, saving valuable physician and staff time while reducing payment delays. Ultimately, ICD-10 may encourage payers to cover more procedures, pay faster and reimburse more accurately.

- **Audit protection** – Using the more precise ICD-10 codes, physicians can paint a much clearer clinical picture with their documentation. This can help ward off a Recovery Audit Contractor audit and reduce the chance of misinterpretation by third parties, auditors and attorneys.