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Legal Concerns and Financial Considerations For Offices Changing EMR's

1. Contracts are only as strong as you are willing to enforce them AND DON'T FORGET to read the fine print

CFHC made several mistakes with the initial contract. When signing a 5 year contract with our local billing company, MBA, we failed to appreciate that by working with "their lender" we had limited recourse once they had the money in hand. We were essentially left with a bank loan, which was guaranteed by my personal assets. Furthermore, we failed to appreciate that the \$55,000 contract payment was immediately divided amongst 3 parties: 1. MBA, in VT, for support and customer service 2. Etransmedia, in NY, for technical support and storage of the data (this is the group notorious for poor customer service) and 3. Allscripts, the software company, located in GA. Having reviewed several contracts now I must say that MyWay had the "best" (aka most comprehensive) contract that met the standards recommended by VITL. With that said, the financial burden would be too great on our office to ever enforce this legally.

2. Ownership lies in possession

Who exactly owns patient information entered into an EMR. The patient, the office, or the company who hosts it? There is not an easy answer to this. Most EMR's state that they will "give you" your data for free on a disk if you choose to discontinue the EMR; but it ends up that that is in a read-only form that is very tedious to access and not functional. To have patient data continue to be meaningful and to meet federal guidelines it needs to be transferred over either manually (which our office is doing) or through electronic migration (which GoodHealth is doing). This process was estimated to cost our office up to \$27,000. In a small office such as ours, additional costs such as this translates to \$27,000 divided by three providers and subtracted directly from each of our salaries. Carolyn from GoodHealth will go into this in further detail.

3. There is no EMR that has it all

It has been very disappointing to me that in the 3 years since I last looked at EMR's there's not one product that has it all and has become the front runner across all specialties. Furthermore, as functionality has improved to meet federal and state guidelines, the ease of use has dwindled. EMR's have become a tool to increase documentation to enhance billing revenue, to reduce exposure in malpractice lawsuits,

and to meet federal incentives. It no longer is a tool of communication between one provider and another. I now get 13 page emergency department notes that have endless structured, pre-scripted text on pain assessment scales, lab or imaging results, or whether the bedside railing was put up; yet they commonly fail to convey the most essential part to ensure continuity of care: a diagnosis or plan for treatment.

4. EMR's are like all other gadgets: the accessories don't transfer over

Changing our EMR requires us to also change the various interfaces for labs at FAHC, Blueprints/DocSite, etc. Although many of these interfaces were covered the first time through federal funding, these will not be offered for offices such as ours that need to change EMR's. Our office will need to get 3 new interfaces. At \$5,000 per interface plus monthly charges, it's hard to swallow. This is in addition to the \$1,400 per month we'll be paying for the new EHR! And no, these costs are not recouped by faster documentation and efficiency.

5. Past mistakes likely WILL be repeated again

EHR companies have variable responsiveness when it comes to negotiating contracts. After surveying other offices who recently changed EMR's, it ends up that none of them even tried to negotiate the contract terms because they "needed" to get onto a system. During this process we worked closely with Dr. Dianne Rippa, of Alderbrook, in an attempt to negotiate new EMR contracts that met VITL's guidelines. This was met with limited success. Ultimately there is little wording to protect our office from going through this same scenario again (not that we would be able to afford to enforce it legally)! Although it is my hope that I will never change EMR's again, it seems likely that Vermont will follow the lead of Colorado and move toward a single EHR with FAHC's EPIC. Unfortunately EPIC is currently is not a viable option for small practices such as CFHC due to its expense, lack of a billing solution for non FAHC-offices, and lack of user-friendliness for a small office.

Other Points to Consider

1. Reimbursement disparities between FAHC and non-FAHC facilities for same services
2. Reimbursement disparities between Blue Cross and Blue Shield and other Private, Federal, and State Insurers and how this will impact practices if we move to a single payer system
3. Insurance reimbursement disparities that allow FAHC to minimize out of pocket copay expenses while collecting higher reimbursement from FAHC employees and families, creating a disincentive for patients to use local, more affordable, non FAHC-services
4. The burden of redundant and time consuming quality improvement measures by state, federal, and private insurers