Making the Switch: Replacing Your EHR for More Money and More Control

athenahealth

Making the Switch:
Replacing Your EHR for More Money
and More Control

Executive Summary

After nearly 30 years of availability, electronic health records (EHRs) have arrived at the forefront of health care policy and practice. HITECH Act incentives are driving widespread adoption. New "meaningful use" requirements and certification timelines are forcing many practices already using EHRs to reconsider their systems and their longer term goals. This whitepaper serves as a guide to identifying an under-performing EHR and replacing it with a solution that delivers results. It offers answers to a number of common questions about EHR adoption and replacement and demonstrates how the right EHR can help practices get more money and more control, freeing up physicians to focus on patient care.

Some of the critical questions to be asked when considering a long-term EHR strategy include:

- Will the EHR achieve the requirements of federal meaningful use measures? Is it guaranteed to secure incentives?

- Is the solution nimble and responsive enough to meet changes to come with health care reform – both anticipated and unforeseen?

- Does the EHR provide a sufficient return on investment (ROI) with regards to both clinical and financial benefits?

- Can practice leadership be confident that they will not need to buy a new EHR in the next five years because their solution has become obsolete?

This whitepaper examines these and other questions and considerations. It offers tips for physicians who may be contemplating a switch and outlines the elements that add up to an optimal EHR solution.

The White House on EHRs

Like his predecessor, President Obama has publicly encouraged EHR adoption. During the annual conference of the American Medical Association on June 15, 2009 in Chicago, President Obama said the nation needs to upgrade our medical records by implementing EHRs4, noting the federal wager of $19.2 billion in the Health Information Technology for Economic and Clinical Health (HITECH) Act.

"You shouldn't have to tell every new doctor you see about your medical history or what prescriptions you're taking. You shouldn't have to repeat costly tests. All that information should be stored securely in a private medical record so that your information can be tracked from one doctor to another — even if you change jobs, even if you move, even if you have to see a number of different specialists. That's just common sense," Obama said.

"And that will not only mean less paperpushing and lower administrative costs, saving taxpayers billions of dollars; it will also mean all of you physicians will have an easier time doing your jobs. It will tell you, the doctors, what drugs a patient is taking so you can avoid prescribing a medication that could cause a harmful interaction. It will prevent the wrong dosages from going to a patient. It will reduce medical errors, it's estimated, that lead to 100,000 lives lost unnecessarily in our hospitals every year."

"So there shouldn't be an argument there," Obama said. "And we want to make sure that we're helping providers computerize so that we can get this system up and running."

A carrot — and a stick

Under the Obama administration, the federal government has taken a heightened interest in EHRs, viewing the digitization of medical records as a critical step in reducing the spiraling cost of health care and improving care coordination. The Health Information Technology for Economic and Clinical Health Act, or HITECH, was signed into law in early 2009, making physicians eligible for $44,000 in total incentives from Medicare (and $63,750 under Medicaid) for demonstrating what the government has identified as meaningful use of a "certified EHR technology," beginning in 2011. Then, starting in 2015, penalties begin to kick in for those who lag behind.

Requirements for meaningful use, released by the Center for Medicare and Medicaid Services on July 13, 2010, include, among other things, the ability to e-prescribe, electronically exchange patient health information, and report on clinical data. The eventual goal is a national health information network. But the immediate impact of the new legislation and incentives has been a rush to adopt for those still managing with paper charts and a cause to reconsider for those stuck with a poorly performing EHR.

The March 2010 KLAS report, "Ambulatory EHR Buying: A Roller Coaster Ride in 2009,"[1] through interviews with 370 providers, predicted that the near future of the EHR market will remain in turmoil despite the massive influx of federal stimulus money. When asked in the report what impact the HITECH Act has had on a practice's purchasing timeline and criteria,[2] 33% of respondents said it increased their incentive to buy and 26% said it sped up their timeline:

> Many providers who were not interested in an [EHR] are now compelled to seek out a solution or be left behind...Driven by the carrot and stick that come with the American Recovery and Reinvestment Act [ARRA] legislation, providers are lining up for their turn on the [EHR] roller coaster. What has been a slow, steady march toward broad [EHR] adoption is now a race against the clock. More than half of providers report having their [EHR] decision sped up or solidified by ARRA, but others say the cost of implementing an [EHR] outweighs the potential incentives.[3]

But even as thousands of providers are getting on the "EHR roller coaster," many who have gone a few laps are ready to get off. Although perceptions of EHRs vary widely among providers in the KLAS report, there is a strong undercurrent of failure and frustration. Fully one-third of practices polled plan to replace their current software-based EHR. For those practices thinking of switching off suboptimal EHRs, the renewed focus from Washington, HITECH incentives, and the release of meaningful use standards are together compelling action. The clock, they realize, is ticking and now is the time to make the break toward an EHR solution that can navigate all the changes ahead.

How one practice made the switch

In 2000, Dr. Thomas Mohr founded Pediatric Partners, a single-site practice with three physicians located northeast of San Diego.

At the time, the medical group installed a software-based EHR and was facing typical challenges from the traditional clinical software.

"Our staff went through extensive training and we also hired outside consultants to help them utilize the software," says Mohr. "It wasn't long after it went live that our staff was experiencing growing frustrations, which only compounded as the new software versions required substantial capital investments in hardware and upgrades. As our practice grew, so did the cost of operating the system."

In 2005, Pediatric Partners felt they needed a new clinical solution, and turned to athenaClinicalsSM, a low-investment, high-return electronic health record service built on a web-based platform. It combines intuitive software with results-oriented services to deliver improved outcomes and return on investment.

Soon after implementing the service, Pediatric Partners experienced something beyond just improved clinical workflow.

"Even with all your labs coming in electronically, there is still a massive amount of paper that comes into a medical office. Having a centrally-hosted EHR service that scans and categorizes every incoming fax, then matches clinical documents to existing patients and patient orders has given our group an incredible amount of process control on both the clinical and operational fronts, not to mention athenaClinicals now manages the connectivity to our labs and pharmacies, which has significantly reduced the number of calls to our practice," Mohr boasts.

By indexing inbound faxes to patient orders, the web-based service provides the basis for enhanced closed-loop order cycle integrity.

Along with eliminating a practice's paper congestion, athenaClinicals provides the typical features of a traditional EHR software system, as well as CCHIT certification and intuitive user interface. It offers continually updated payer-specific coding rules and E&M coding reviews of the point-of-care. This helps providers optimize reimbursement for practice-specific pay-for-performance (P4P) payer contracts.

Today Pediatric Partners has 20 physicians in 10 locations—up from two locations in 2000—and serves 100,000 patients a year. Its providers see 150 new patients a month and service five hospitals.

Mohr said his EHR service has allowed the practice to flourish. It "demands consistency from the practice to address the clinical work in the workflow dashboard and allows us to tie provider compensation to how well they manage their buckets of work," he said. "I now have real-time visibility into all my practices, giving me the ability to manage my staff at the user level."

EHRs slow to fulfill promise

Despite decades of availability, the adoption of EHRs within the medical community has been a slow and rocky process. While 38% of doctors have adopted an EHR, a scant 4% use the full functionality of the system, according to the New England Journal of Medicine.[5] A recent study of emergency rooms by the W.P. Carey School of Business at Arizona State University found that the total length of stay for patients was 22% shorter at hospitals with "fully functional" EHR solutions than those without.[6] Unfortunately, it also found that only 1.7% of the EHRs being used fit the "fully functional" definition. These statistics underscore the fact that even where adopted and implemented, the full promised benefits of EHRs have yet to materialize for most doctors. And where some see only promise and potential, others continue to see only threats and risks, as a study from the Harvard Journal of Law and Technology captures:[7]

Despite the many potential benefits of [EHR] systems, they are not an unalloyed good. Their design, implementation, use, and maintenance raise important concerns that must not be overlooked. [EHR] system failures can cause significant injury and cost lives. Unauthorized disclosure of electronic health information can also lead to large scale privacy breaches, and the cost of implementing EHR systems may threaten the financial viability of some medical practices. The risks generated by these complex software systems are sufficiently serious that they demand regulatory oversight.

The high up-front costs of legacy software systems—and the often herculean effort to implement them—have kept many doctors wary. "If this is a cost saver, I don't get it," stated one EHR-using nephrologist in a Boston Globe article.[8]

Some observers have commented that the massive infusion of federal dollars with the HITECH Act could have the unintended effect of providing artificial life support for overpriced, outdated legacy software systems. "It appears that the deck has been stacked in favor of incumbent and legacy organizations," said David Kibbe, a medical informaticist and senior advisor to the American Academy of Family Physicians. "The state of electronic health records available today is equivalent to the mainframe computer world in 1982. Imagine that the federal government had come in and said, 'We're not going to let DEC fail'."[9]

The case to replace

The March 2010 report from KLAS included a section entitled "Why are some [EHRs] being replaced." It explains that a growing number of practices are swapping their EHRs due to fears that the system won't measure up to standardizations for meaningful use. And even some systems with current CCHIT certifications aren't a good fit for practice needs and aren't driving the financial and clinical results practices need. The KLAS study[10] reported that for practices of all sizes replacing an EHR:

- 19% complained of missing functionality

- 3% were consolidating their system under a single vendor

- 11% reported doctor dissatisfaction

- 10% pointed to integration problems

- 9% cited support issues

- 7% reported scalability concerns or high expenses

- 5% complained that the EHR did not meet specialty needs or a hospital was pushing a change

- 4% reported technical problems

Clearly, there's a variety and range of causes behind the uneven reputation of EHRs. Missing functionality is a wholly different problem than a decision—possibly coming down from an affiliated hospital—to consolidate systems. Separately or combined, there are a number of good reasons to consider replacing an existing EHR solution.

Too expensive, not enough return

EHR software can be an expensive and daunting investment for medical groups. It is generally priced on a per physician basis, so the larger the practice, the more quickly the costs spiral upwards. It is estimated that the cost of purchasing a traditional EHR system is $33,000 for each physician, with an additional cost of $1,500 per

doctor per month for maintenance.[11] Per physician, this translates to $51,000 in costs during the first year of using an EHR and $18,000 in annual maintenance costs. High-end legacy systems are often paid for upfront by amortizing costs over as much as fifteen years even though the normal life of most software is just five years. With this pay-up-front scenario, traditional software vendors have little incentive for delivering a promised return on investment (ROI).

In a 2010 survey[12] of 1,000 doctors conducted in the Sermo online physician community, 81% have a favorable opinion of EHR systems in general, yet most doctors consider EHRs too expensive to purchase (90%), to install (89%) and to maintain (81%). Another study[13] by the Texas Medical Association (TMA) in 2009 reports 41% of practices found that actual costs were on average 31% higher than the vendor estimated. The TMA, an organization of 43,000 physician and medical student members, compiled a helpful list of other unexpected expenses.[14]

- Other training costs (e.g., computer-based tutorials, hired trainers)

- Office staff backfill costs (while staff are in training, assisting with design, development and/or implementation)

- Temporary labor (initial EHR data entry, scanning the paper-based medical records)

- Self-service kiosks including software and services (Note: some EHR vendors provide this at an additional cost)

- Temporarily reduced income (reduced schedule at EHR go-live; amount is variable and dependent primarily on the practice and EHR functionalities installed)

- Office construction and furniture (e.g., shelves, counters, wall mounts, power outlets, chairs, carts, tables)

- Technical upgrade of office infrastructure (i.e., wireless network, upgraded network connectivity)

- Additional hardware and devices including networking devices, scanners, printers or kiosk devices

- Consultants or project manager to facilitate the implementation (large practices in particular should strongly consider using a consultant to help manage the EHR selection, implementation and postimplementation phases

- Other technical services

With the traditional EHR incurring high up-front costs, pricey upgrades and hidden maintenance fees, owning one can quickly lead to throwing good money after bad.

Too slow

Physicians often complain that an EHR, though sold as a tool for greater efficiency, can consume more time than it saves. Recent studies have reported as much as a 10–15% drop in productivity and a corresponding $7,500 decline in revenue per physician as the result of implementing an EHR.[15] These findings are consistent with those of the TMA, which reported that 50% of survey respondents[16] found data-input "difficult or time-consuming," some 37% found new kinds of errors possible with an EHR, and 32% reported reduced productivity.

And if an EHR is not up to saving time today, it probably won't work in the future as providing care grows more complex. Paul Carlin, M.D. and team leader at Valley Medical Group in Greenfield, MA said an EHR must be able to quickly cut through complexity and put the facts together at the point of care. "A lot of medical care comes down to information management, understanding what patients need, what they've had, where they need to go, who they've seen, what needs to happen next in coordinating their care. People are getting sicker and older and more complicated and so increasingly it's hard to do that in a world of paper and pen." If the EHR cannot place that information at a provider's fingertips at the point of care, the practice is slowly falling behind with each increment of each encounter.

Along with negatively impacting physician productivity, the wrong EHR has the potential for more serious consequences. As Harvard researchers found, "products with poor information display and navigation can impede rather than facilitate providers' work. The growing capabilities of [EHR] systems require increasingly complex software, which heightens the danger of software failures that may harm patients."[17]

Too much work and hassle

Along with being costly, many EHRs only add to the workload in a practice, putting the burden of getting paid through meaningful use or through Pay for Performance (P4P) programs squarely on the shoulders of physicians. The number of P4P sponsors jumped from 39 in 2003 to 148 in 2007, many with multiple programs targeting differing provider types.[18] And there are new government and payer programs appearing all the time. Staying on top of new requirements and new opportunities can overwhelm a practice and prevent it from taking advantage of all the incentive programs it qualifies for. An EHR vendor that manages all the tasks needed to identify, enroll in, configure for, report on, and chase down available program money will have a strong defense against new costs.

A lack of closed-loop ordering forces practices to spend valuable time chasing down orders. Without robust document services support, a practice must take on the time-consuming and burdensome administrative tasks associated with processing what typically adds up to more than a thousand documents per doctor, per month[19]. The paperwork associated with each patient can be staggering and labor-intensive with documents moving through the practice from referring providers, labs, pharmacies, payers, employers, schools, etc. Multiply that administrative load by the number of patients, factor in the actual labor of reminder calls, chart pulls and filing and soon a practice is mired in document work that takes staff away from more valuable work. Document work represents a major pain point and a significant cost drain for a practice. An effective EHR vendor should take on the bulk of your paperwork and most labor-intensive administrative tasks, so you can focus on providing care and growing your practice.

Too far behind on meaningful use

Some EHR vendors have been caught flat-footed by the waves of health care reform coming out of Washington and are still not prepared to guarantee meaningful use certification, let alone guarantee that you'll receive your HITECH Act incentives. Being stuck with an EHR that is slow to respond and adapt to new requirements could put a practice's incentives at peril or lead to additional practice work and costs for software upgrades just to meet standards.

According to the American Medical Association, the EHR industry as a whole is not up to the task. An AMA executive provided a lengthy memo to the association's board of trustees on July 20, 2010 regarding the "Final Rule" on meaningful use.[20] In a section that listed lingering challenges, the first item described a lack of products now able to meet the standards that were announced on July 13.

In their March 2010 study, KLAS asked providers about their confidence in demonstrating meaningful use with an EHR, and their perception of whether vendors are ready to meet the new standards. They found that a vendor willing to match dollars with performance was perceived as the most likely to meet meaningful use. When asked why the vendors that are on track to meet meaningful use were "so close," 38% of respondents stated it is because the vendor has committed to a guarantee.[21]

If you have a vendor that is taking your money up-front, adding to your workload while undermining productivity, and not guaranteeing or committing to real outcomes, it is probably time to consider making a switch.

Replace and optimize

The HITECH Act and the federal incentives it has made available will drive thousands of practices to adopt EHRs. But now the race is on and it may be a treacherous course for some. Yet as much as it may feel like a high stress situation, this is the time that practices should make calm, rational decisions in selecting an EHR rather than sprinting blindly into a potentially destructive arrangement.

With the problems outlined above, we could potentially see practices going out of business or handicapped if they remain stuck with unwieldy, costly EHR systems. This kind of large-scale mandate to improve health care efficiency is commendable. But as the evidence in the KLAS report and other sources cited here reveal, federal stimulus money will not solve the flawed economics of many EHRs in the market today.

With the pressure mounting, those stuck with an underperforming model need to look for a solution that can assure a rapid and smooth implementation, guarantee meaningful use reimbursement, and provide the close support over time to ensure the practice succeeds operationally and financially.

Traditional EHRs cannot keep pace with the rapidly changing, increasingly pressurized health care environment, including P4P rules and new meaningful use incentives, without burdening the practice with significant added costs. While the dangers of keeping an underperforming model are looming and real, the benefits of replacing it with one built for speed, adaptability and scalability are tangible and bankable.

For practices considering a switch, it's important to seek out a solution that not only satisfies all the critical needs of an effective EHR, but one that is capable of making the transition to a new system as quick, smooth, and painless as possible. Some of the key areas to probe in evaluating EHR candidates include their implementation process and track record, data migration approach, workflow design, and total cost of ownership.

Quick and easy implementation

A rapid and smooth implementation is critical to achieving adoption goals as well as long-term success. On the one hand, an implementation that drags on over time and slows down a practice can inflict permanent damage. And it does happen. According to a 2009 Medscape survey, 60% of implementations took more than six months and 22% took more than a year.[22] The U.S. Office of the National Coordinator for Health IT reported in 2007 that 50% of EHR implementations failed. And for a practice already facing pressure from all points, a failed implementation means wasted time and financial loss.

On the other hand, well-conceived implementation plans make it easy to replace an old EHR. And good planning comes with positive downstream effects. Done correctly it can have the unexpected benefit of making staff a more cohesive and successful team due to the shared experience. The well-executed implementation can strengthen and unite a practice rather than weaken it by slowing it down and spawning frustration.
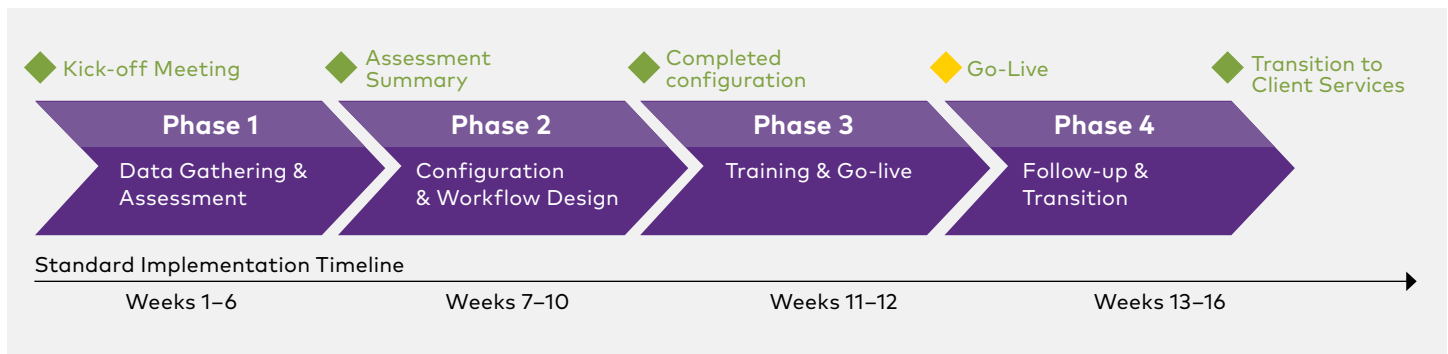
Depending on the size of the practice, the right vendor can deploy an implementation team on-site or get the system up and running over the Internet. The implementation team should be available to help the practice tailor its documentation method so that it best fits the provider workflow, technical skills and capacities. It's done without changing normal patient schedules and thus preserves, or even enhances, patient throughput.

Look for vendors that leverage the experiences of other clients and use their software and services to provide the best possible solution for your practice. Ensure that they can offer:

- Specialty-specific pre-configuration to reduce implementation effort for the practice.

- The ability for the practice — with assistance from the implementation team - to modify pre-configured content to optimize their implementation.

- A vendor-maintained global repository of clinical content (based on the experiences of other live practices) and data sets, such as clinical findings, medications and other orderables, code sets for billing, etc.

Unlike the long installations that are common with software-based systems, a web-based service can be implemented rapidly, often in as little as 6–10 weeks, as this timeline for a typical practice implementation illustrates:

Figure 1: Web-based Implementation Timeline for a Six-plus MD Practice

Kick-off Meeting | Assessment Summary | Completed configuration | Go-Live | Transition to Client Services

Phase 1 — Data Gathering & Assessment
Phase 2 — Configuration & Workflow Design
Phase 3 — Training & Go-live
Phase 4 — Follow-up & Transition

Standard Implementation Timeline

Weeks 1–6 | Weeks 7–10 | Weeks 11–12 | Weeks 13–16

With few or no technical activities such as server acquisition, installation and testing, the implementation

largely becomes a series of workflow and configuration decisions. During each phase, the vendor and the practice each have clear roles so the objectives within each phase can be met effectively and on time. A practice can be confident that a vendor with a proven approach will deliver a consistent and efficient implementation process. Coupled with the ability to leverage the 'network effect' of client experiences, this type of approach will bring best practices to the process, maximizing performance and minimizing operational and financial disruptions. Finally, the practice can be confident that it will be able to adopt new methods and technologies in a meaningful way. Once the implementation is complete, the right vendor stays with a practice to provide ongoing training and support as part of the web-based service.

Smooth data migration

One of the greatest concerns with replacing an EHR is the process of migrating data from the old system to the new one. Even before electronic records were available, there were years of patient data stored in paper files in row after row and shelf after shelf for every medical practice. There is no questioning the value of an accurate health history, but a practice must evaluate the cost of data conversion against the declining value of historical data in day-to-day clinical operations. Some data unlikely to be needed in the context of routine patient care may serve the practice just as well by residing in an offline archive that can be accessed as needed. Data conversion should not drive the EHR selection process. Rather, this one-time conversion effort should be one of many other important selection and implementation steps taken along the way.

One-time data conversion is just one of many interoperability needs in the EHR space. While the use of continuity of care documents (CCD) is becoming the standard in interoperability and clinical data exchange, most EHRs that practices are abandoning cannot readily export patient data in a CCD format for easy import into the new system. To address this gap in the client's old EHR, proactive vendors have found ways to extract data from the databases of these legacy EHRs and then import into their new systems.

They work with practices to prioritize and extract historical information such as problem lists, medications, allergies and immunizations from the old system following a CSV (simple text format) or delimited format provided by the vendor. Often the practice will employ a third-party vendor to execute the data extraction and mapping. The practice should always conduct its own quality assurance checks to ensure accuracy and proper data mapping. Due to the potential for transcription errors and other flaws, a test import should be completed in a preview environment.

Improved workflow

Traditional EHR systems focus narrowly on the physician exam, missing key opportunities to improve efficiency and revenue potential throughout the patient workflow. This approach can slow providers down and fails to automate results and order management, one of the practice's biggest staff costs. As mentioned earlier, these EHR software companies don't have the ability to stay on top of new P4P and quality care incentives.

As a business services provider, the right vendor recognizes that what's often broken are the workflows around the physician. EHRs have a unique potential to introduce efficiency, leveraging staff to maximize physician time with patients, while leaving the physician to document the exam according to his or her preferences. By expanding the power and potential of the EHR beyond the physician exam to the entire patient workflow, the burden of a successful implementation can rest more with the staff than with the physicians. An optimized EHR solution encompasses the entire clinical workflow, including pre- and post-patient visit activities. It takes away the burden of excessive data entry during the clinical exam, providing the doctor with flexible charting options—including voice recognition software—to ensure he or she is not slowed down.

A good workflow design incorporates closed loop order and document management. And every step of the workflow is tracked and benchmarked against other practices to allow for continual optimization of efficiency and revenue potential.

A well-designed workflow makes the right information available at the right point in the patient encounter. Not only does this translate into better care, but it also translates into more revenue from P4P and other quality care programs. As Joel Feinman, PhD, and President of Valley Medical Group in Greenfield, has put it:

> We really can't rely on the old methods, paper-based methods, phone-call based methods. We have to have systems that at the point of care can remind doctors, nurses, here's the procedure, here's the question to ask, here's the thing to provide to this patient right now so that their health is improved and maintained and our practice keeps providing for their needs.

ROI and Total Cost of Ownership

An EHR that will pay off over the long run should be designed to uncover and bank P4P bonus revenue and should come with guaranteed HITECH Act incentive payments. A web-based CCHIT-certified EHR can respond to government mandates and changes faster than software that needs to be updated or patched. The right web-based service also enables a practice to maintain or even improve patient throughput after implementation, driving consistent and growing revenue.

And by implementing a web-based service, a practice avoids the capital cost of expensive servers and other hardware, as well as licensing fees, software packages, and other often hidden expenses that come with most software and ASP solutions. Low upfront cost married with a service that uncovers and obtains new sources of practice revenue can provide a satisfying return on investment.

Cost Category	Cost Incurred?		
	Software	ASP	Web-Based Service
Implementation	Yes	Yes	Yes
Hardware investment	Yes	Yes	No
Monthly subscription	No	No	Yes
Ongoing license fee	Yes	Yes	No
Ongoing Training	Yes	Yes	No
Regular upgrades	Yes	Yes	No
eRx	Yes	Yes	No
Lab interfaces (e.g., Quest/LabCorp/hospital)	Yes	Yes	No
Document Management	Yes	Yes	No
Maintenance costs	Yes	Yes	No
Performance Insight	Yes	Yes	No

There's an important distinction to be made between cost and price. An EHR may look attractive because of its low sticker price but practices should consider the total cost of ownership (TCO) and be prepared tointelligently compare the TCO of competing solutions and models, as illustrated in Figure 2.

It has been estimated that with software purchases, for example, the upfront purchase price of the software accounts for just 10% of the total cost.[23] So if a practice is upgrading to a substantially different version of a piece of software, it would likely have all of the normal implementation costs (e.g., training, consulting, template development, new hardware). In some cases vendors charge for an upgrade if the version is significantly newer and/or the practice hasn't paid a license fee in five to eight years. This can make the cost of an upgrade as high as purchasing and implementing a new solution. By switching to

a web-based system without the lifecycle costs, as illustrated in Fig. 2, a practice can maintain a relatively low TCO and save significantly over time.

A better way to financial health.

The good intentions of the HITECH Act will be a largely wasted effort if the EHRs that proliferate as a result don't meet meaningful use or lead to widespread adoption and full use. In the same way, keeping an EHR solution that can't guarantee your incentives and doesn't optimize your practice for revenue and performance will continue to be a drain on both time and money.

An underperforming EHR poses a serious economic risk for a practice. The high rates of failed implementations and the high levels of dissatisfaction among doctors with their current software prove that many EHRs persist as liabilities to medical practices rather than assets for growth.

But there is a better way.

A well-designed EHR can minimize the huge costs of implementation and maintenance, help your practice uncover and bank new incentive revenue, and take away the burden of clinical paperwork starting on day one.

With a web-based service like athenaClinicals, there's no cost or hassle of buying servers, paying for upfront licensing fees or installing costly software. With a low up-front investment, a computer, and an Internet connection, your practice can become part of a strong, growing nationwide network. As a web-based service with an easy, rapid, and reliable implementation process, we can make the daunting process of switching EHRs as seamless and painless as possible for your practice.

athenaClinicals provides a unique model that addresses, head-on, the barriers to EHR adoption and satisfaction. At athenahealth, we deliver greater clinical control and insights to medical practices while boosting efficiency and revenue potential. Our integrated, web-based, CCHIT-certified EHR software adapts to government mandates faster and is on track to meet meaningful use requirements. At no additional charge, our back-office services electronically sort and route to charts all faxed and electronic clinical information – we even build and maintain electronic connections with labs, pharmacies, hospitals, and health information exchanges. Together, our services give you more money and more control over your practice and the care you want to give.

To learn more and to find out about our federal stimulus incentive Guarantee, visitathenahealth.com or call 866.817.5738.

Endnotes

1. KLAS. "Ambulatory EHR Buying: A Roller Coaster Ride in 2010." March 2010.

2. KLAS p. 79.

3. KLAS pages 5 and 11.

4. Remarks by the President at the annual conference of the American Medical Association, June 15, 2009, Chicago. http://www.whitehouse.gov/the-press-office/remarks-president-annual-conference-americanmedical-association.

5. DesRoches, C. et al. "Electronic Health Records in Ambulatory Care-A National Survey of Physicians." *NEJM*, 359(1): 50-60.

6. Hobson, Katherine. "Only Advanced Electronic Medical Records Reduce ER Time." *Wall Street Journal*, Aug. 18, 2010.

7. Hoffman, S. and Podgurski, A. "Finding a Cure: The Case for Regulation and Oversight of Electronic Health Record Systems." *Harvard Journal of Law & Technology*, 22(1) Fall 2008, p. 106.

8. Arnst, Catherine. "Doctors not in stampede to go digital." *Boston Globe*, May 4, 2010. http://www.boston.com/news/health/articles/2010/05/04/for_some_doctors_national_computerized_medical_records_dont_pay/.

9. Keim, Brandon. "Obama's Computerized Hospital Vision May Have Blind Spot." *Wired*, July 15, 2009.

10. KLAS p. 82.

11. Gans, D. , Kralewski, J., Hammons, T. and Dowd, B. "Medical Groups' Adoption of Electronic Health Records and Information Systems." *Health Affairs*, 24:5 pp.1323-1333. 2005. Miller, R.H. et al. "The Value of Electronic Health Records in Solo or Small Group Practices." *Health Affairs*, 24:5 pp.1127-1137. 2005.

12. 2010 Physician Sentiment Index: Taking the Pulse of the Physician Community, athenahealth & Sermo. February 2010. p. 11.

13. Texas Medical Association. "Special Survey Electronic Medical Records (EMRs) – 2009 Report." http://www.texmed.org/uploadedFiles/Practice_Management/Computers_And_Software/2009%20EMR%20Survey%20Flyer.pdf.

14. Texas Medical Association. "How Much Will an EMR Cost?" http://www.texmed.org/Template. aspx?id=7709.

15. Gans et al, 2005, Miller et al, 2005.

16. Texas Medical Association Special Survey Electronic Medical Records (EMRs) – 2009 Report.

17. Hoffman S. and Podgurski, A. 119.

18. Blue Cross Blue Shield Association. "Healthcare Trends in America: A Reference Guide from BCBSA (2009 edition)," p. 48. http://www.bcbs.com/blueresources/healthcare-trends-report/2009/.

19. athenahealth data.

20. Hobson, Katherine. AMA Weighs in on "Meaningful Use' Requirements for E-Records." *Wall Street Journal*, July 20, 2010. http://blogs.wsj.com/health/2010/07/21/ama-weighs-in-on-meaningful-use-requirementsfor-e-records/.

21. KLAS p.76 (p.77 in PDF).

22. Kane, Leslie R. MACC. "Electronic Medical Record Survey Results: Medscape Exclusive Readers' Choice." *Medscape Today*, Oct. 6, 2009.

23. MacCormack, Alan. "Evaluating Total Cost of Ownership for Software Platforms." *AEI-Brookings Joint Center for Regulatory Studies*, p.2.

Notes

we connect care™

A leading provider of cloud-based services and mobile tools for medical groups and health systems. Our mission is to be the most trusted service to health care providers, helping them do well by doing the right thing.

athenahealth