



ACP Observer

- Contents
- Current Print Issue
- Past issues
- 2006 Editorial Calendar
- Special Observer Supplements
- Articles by Subject
- CME Bulletin Board
- Subscription Info
- Reprints & Permissions
- Permission
- Observer Staff
- Mission

Classifieds

- Physician Jobs
- Physician Products and Services (Non-ACP)

Information for Advertisers

- Pharm Advertising
- Non-Pharm Advertising

Search ACP Observer

- Printer-friendly format
- Email this page

A small practice juggles EHR's high costs and big payoffs

High-tech tools give physicians more time with their patients—and better reimbursements from insurers

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By Janet Colwell

Many physicians are holding back from buying electronic health records (EHRs), worried about the investment in time and money.

But that investment has paid off for a two-physician practice in Northern Virginia. Since they adopted their first system more than a decade ago, the two partners have slashed their burden of paperwork, increased time with patients, given themselves more time with their families and convinced health plans to boost reimbursement rates.

But to reap those rewards, both physicians have had to work hard to balance their high EHR costs with their health plan reimbursements.

"Having an EHR allows our practice to run more smoothly, but when it comes to the bottom line, the economies of scale aren't there," said Anne Rose N. Eapen, FACP, who launched Internal Medicine of Northern Virginia with Samuel M. Shor, FACP, in 1994. "We've had to be picky about the insurers we work with to make sure their fee schedules cover our higher cost structure."

Sidebars:

- [What to look for when you're shopping for an EHR](#)
- [Adding up the costs](#)

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—Anne Rose N. Eapen, FACP

Getting up to speed

The field of EHR products was much narrower back in 1994 when the two physicians established their practice in Reston, Va.

Drs. Eapen, 43, and Shor, 51, launched their joint practice after working together for four years in an independent practice that used a very early and crude EHR. The goal in setting up their current practice was to take EHR to "the next level," Dr. Shor said.

Back in 1994, he spent several months researching products, meeting

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with vendors and making site visits before deciding on a system. He opted for ClinicaLogic, created by MedicaLogic, which is now owned by GE Medical Systems. The partners still use the same system. (See ["What to look for when you're shopping for an EHR."](#))

"Installing the system at startup turned out to be an advantage," Dr. Shor said. "We had time to learn the system and train staff while our patient load was still relatively light."

The physicians have refined their system as their practice has grown and changed. While they've always had the ability to track individual patients, said Dr. Eapen, they only recently learned how to generate reports based on different disease categories.



Drs. Eapen (left) and Shor say they've had to be very selective about the insurers they work with.

The partners are now modifying system software to develop new templates that track patient populations with diabetes, hypertension and heart disease—diseases targeted by disease management and pay-for-performance programs. The system can also track specific tests or screenings, such as the percentage of diabetic patients who had their urine checked in the past year.

With their EHR now running smoothly, the idea of measuring and reporting patient progress seems far less daunting, Dr. Eapen noted. "When pay for performance hits us in a year or so," she said, "we will definitely be ready."

Balancing the books

That said, having an EHR has sharply increased their practice costs.

Startup expenses were steep, including a \$6,000 upfront software licensing fee (in 1994 dollars), \$5,000 in consultant fees to handle implementation and training, and \$10,000 for an on-site local area network server.

The office is equipped with 16 different laptop or workstation units, at \$1,000 a pop. (The practice has a workstation in each of seven exam rooms, as well as individual units for the two physicians, three nurses, two administrative personnel, and one data management person.) The practice pays \$5,500 a year for ongoing EHR maintenance and support, and more than \$3,000 a year for a consultant who makes sure the hardware is properly configured and the software interacts as designed. (See ["Adding up the costs."](#))

To make those investments pay off, the partners made some hard decisions about how they wanted to grow and manage their office.

"We could have expanded our practice by adding a physician a year and taking on more and more insurance products," Dr. Eapen said. "But we decided we weren't going to grow an empire of physicians. We were going to stay small so we could know our patients and address all their

needs."

To make it work, Drs. Eapen and Shor decided from the start not to participate in capitated insurance plans. Since then, they have also limited their participation in Medicare and some PPO plans.

"Our payer mix is better than the average practice," Dr. Eapen said, pointing out that their patient population breaks out into 15% Medicare, 45% self-pay and 40% PPO. "It has to be to allow us to afford our EHR." She added that their reputation, based in part on their use of an EHR, has helped them to attract a high number of self-paying patients in the Washington metropolitan area.

They've also argued for—and won—better payments from some insurers.

Last year, the physicians wrote to health plans, asking for increased reimbursement based on their ability to deliver better quality care with information technology. The letter pointed out the practice's clinical and safety advantages, including more complete, legible and easily accessible patient records; a built-in drug interaction checking system to prevent errors; improved tracking of preventive screening and other necessary testing and follow-up; and ready access to patient information handouts on medical conditions and medications.

They also noted in the letter that only about 5% of private physician offices in the country currently have EHRs in place and that neither doctor had ever been sued or audited—a fact they attributed in part, they said, to quality improvements made possible by their EHR.

An impressive 60% of insurers who received the letter agreed to either raise reimbursements across the board in the first quarter of 2005—by an average of 55%—or boost payments for the top 20-to-30 most frequently billed procedures. In the second quarter of this year, the physicians stopped participating in the plan that historically had the lowest reimbursements, after the insurer failed to offer a reimbursement increase.

The results went straight to the bottom line: In the first quarter of 2005, the practice's gross revenue increased by 30% compared with the same period last year. In the second quarter, after dropping that lowest-paying insurance plan, practice revenue increased by 8% compared with the same quarter in 2004.

Extra dividends

Both physicians say that the EHR has allowed them to spend more time with patients and provide better service. They routinely spend between 15 and 20 minutes or more with each patient—and hand patients printouts of their medications after each visit. Instead of spending extra hours in the office writing up chart notes, Dr. Shor said he accesses the system from home through a virtual private network. Being able to review charts, fax documents and get patient education materials with a few simple clicks, he added, is a huge time saver over using a paper-based system.

And when it comes to lifestyle, both physicians see patients the equivalent of four days a week, allowing them to more effectively balance work and family.

"Having an EHR doesn't necessarily save money," said Dr. Eapen. "But

there is a significant quality of life issue that you can't put a dollar value on."

[Top](#)

Adding up the costs

According to Anne Rose N. Eapen, FACP, who along with a physician partner launched a paperless practice in 1994, the cost of software to run an electronic health record (EHR) program is fairly standard from vendor to vendor.

However, physicians have some flexibility when it comes to investing in hardware. The following is a basic breakdown of what the two-physician practice spent to set up and maintain its system:

Start-up costs:

- \$6,000 per physician to license the software (in 1994).
- \$5,000 for training (in 1994).
- \$15,000 for practice management software (in 2003).
- \$12,000 for a consultant to handle implementation and training.
- \$3,500 for additional software to link the EHR to outside laboratories, with potential to link to other vendors. (Practice staff has to process digitally faxed documents and scan paper faxed or mailed reports. These are then stored on a server and transferred into the EHR.)
- \$10,000 for a local area network to keep data on an on-site server.
- \$2,000 for a document fax server.
- \$2,000 for a third server that acts as a data transfer station.
- \$2,000 to launch a Web site.
- \$1,000 per computer laptop or workstation, with 16 units altogether. The practice decided to put relatively inexpensive workstations in each of seven exam rooms so the physicians don't have to carry laptops from room to room.

Ongoing maintenance costs:

- \$5,500 a year for ongoing maintenance and EHR support.
- \$1,000 annual support fee to maintain links to outside radiology groups and other consultants.
- About \$300 per month for an information technology consultant who ensures that all the software programs interact with each other and the hardware is configured correctly.
- Small ongoing Web site maintenance fees.

[Top](#)

What to look for when you're shopping for an EHR

When Anne Rose N. Eapen, FACP, and Samuel M. Shor, FACP, started shopping around for an electronic health record (EHR) system in 1994, there weren't many systems to choose from.

But according to Dr. Eapen, the same principles they used should guide anyone considering a purchase today: Look for vendors with long, proven track records whose products can be customized to your needs and can communicate with other systems.

'The concern physicians should have is whether these EHR programs will allow data sharing.'

—Anne Rose N. Eapen, FACP

"A lot of physicians want to wait [until national standards are adopted] but as long as you choose the right vendors, they will do the work for you," Dr. Eapen said. "The concern physicians should have is whether these EHR programs will allow data sharing, given the fact that standards and system requirements can differ from vendor to vendor."

Drs. Shor and Eapen—who have made their two-physician practice in Reston, Va., a completely paperless one over the last two years—have refined their system as their practice has grown and changed. Here are their recommendations for "must have" features:

- Rapid access to charts, literally "at your finger tips." For example, when you're on the phone discussing a patient, rather than having staff "track down" a chart, you should be able to get to the patient's chart with just two or three keystrokes.
- The ability to document notes thoroughly, quickly and efficiently, and to transfer information to patient charts. You should, for example, be able to easily download lab and diagnostic testing results, and reports from reference labs, imaging centers and subspecialists.
- The ability to customize standard vendor templates based on special needs or patient populations. Dr. Shor, for instance, sees many chronic fatigue patients and has customized templates to document their history, test results and treatments. Vendors usually provide training on how to create your own templates.
- A strong pharmacy component and complete library of current drugs that are updated at least four times a year. These functions let you easily check drug interactions and crosscheck against allergies noted in the patient's chart. Some programs also produce sheets on side effects that you can give patients when prescribing a drug.
- A built-in coding advisor to make sure your documentation justifies what you intend to charge for the visit. This function helps prevent both undercoding and unjustified charges.
- The ability to print out handouts to give patients at the end of each visit.

[Top](#)

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