EHR IMPLEMENTION -- CASE STUDY #1

THE EVERETT CLINIC
Everett, Washington
Sharon Cordisco, Transcription Manager

Background

The Everett Clinic is a physician-owned primary and specialty care group with eight satellite offices and two ambulatory surgery centers.

Pre-EMR Implementation

- Provider and mid-level count near or higher than current 2009 numbers.
- Transcription staff: **25** employees (1 manager, 2 leads, 1 print clerk, 1 QA, and rest full or part-time transcriptionists). Additionally, outsourced 50-60% of our daily volume to 1-2 outsource companies. We also required temporary on site staffing for 1-2 years.
- Dictation averaged 6200-6300 minutes per day Monday through Friday and up to 150 minutes on weekends. Majority of providers dictated.
- Primary and specialty care transcription, 25 work types including surgical procedure notes, progress note, and specialty report work types for cardiology, nuclear medicine, pathology, surgery, and others. We also did occasional PowerScribe SRT edits for Advanced Imaging and separate pathology report transcription system for about 6 months.
- Turnaround time preference was 24-48 hours for all but stats; TAT on stats was 2 hours or less. Best TAT met the preference. Worst was up to 12 days behind.

Post-EMR Implementation

- Provider and mid-level count as of 11/1/09: 311 physicians; 79 mid-levels.
- Transcription staff: **3** employees (1 manager, 2 transcriptionists). One outsourcing company. We outsource 50% of our current volume.
- Dictation averaging 400 minutes per day Monday through Friday and up to 75 minutes on weekends.
- Primary and specialty care transcription, only 5 work types, for only 35-40 providers who continue to dictate. No pathology (separate system and transcription group outside of facility). No PowerScribe edits (radiology does 100% self-edit).
- Turnaround time of 24-48 hours or less is standard with a few exceptions during staff or outsource company deficit. During summer of 2009, we were able to achieve same day TAT on majority of jobs and able to discontinue outsourcing as staff could handle the entire queue.

Discussion began in 2006. Leadership team (administration, accounting, physicians) felt we were at a crossroad, and timing was right to make decision on whether or not to continue to develop our internal computerized medical record system or pursue investigation and purchase of a vendor product. Goals included improving patient safety, reducing/eliminating paper, and a desire to be on the cutting edge in meeting likely federally-mandated expansion of integrated health records across the country. Reduced transcription and HIM costs were the primary components of the return on investment. There was also

discussion about whether or not we could enhance our systems fast enough to accommodate future growth and IT requirements. We have always been proactive and on the cutting edge of technologies and services for our patients and customers.

Project Scope and Goals

Goals

- Improve patient safety/standardize documentation/eliminate paper charts.
- Meet ROI goals by 80% reduction in dictation within 2 years.
- Reduce cost in transcription and HIM departments.
- Complete documentation of patient care at time of service or as close as possible.
- Improve access to information.
- Use reporting tools and other functionality to information relating to disease management, results review, turnaround time, reimbursement, and other metrics.

Project Scope

The scope and layout of the project was extensive, involving every layer of the organization. Project goals and monitoring of progress were communicated throughout. Every department was involved in design/build/validation of functionality prior to the go-lives, though this was very challenging in many areas. Vendor team and IT and training teams were on site throughout pre- and post-implementation. Followup plan for support, analysis, and enhancement continues to present day. With this particular EMR, ability to enhance or have much input into the functionality of dictation/transcription workflow was very limited. We were also limited by inability to customize and by budget constraints. The goal was to work with the existing product as much as possible and to streamline our workflow so that minimal-to-no customization was required, particularly during Phase I of the project.

Transcription anticipated the impact to our team would be potential for layoffs as dictation declined and the possibility that department could be eliminated despite claims to the contrary, but we also hoped we would gain a more streamlined workflow, learn new technology including potential for SRT editor role, and reduce our outsourced transcription needs to back-up coverage for staff vacations or unanticipated variation in workload only.

Guiding Principles--Challenges, Outcomes, and Impact

There were many challenges to transcription from start to present. Our guiding principles were to continue the process of documenting patient care efficiently and accurately, to improve turnaround time to a consistent 24 hours or less, to learn the new technology, to incorporate as many electronic workflows as possible to improve and enhance productivity, and to be more cost-effective by doing more work with fewer people. We also looked forward to reducing dependence on outsourcing by limiting the need to provide coverage for vacation, sick leave, or unanticipated variation in workflow. We were enthusiastic about reducing paperwork and processing. We were proactive and engaged in designing workflow and learning how the EMR's functionality would apply to our workflow.

The end result for our department in transitioning to the EMR is summarized below:

- Reduced productivity which, while improved, did not return to pre-EMR levels. This was true for every staff member regardless of individual productivity. This particular EMR's functionality for dictation/transcription is limited as it was not designed for transcription. Numerous work-around solutions were required to accommodate clinical and transcription workflow. Much of this, including training manual, was designed and implemented by transcription staff. System is template-driven with emphasis on drop-down lists and canned phrases/templates with direct data entry by clinical staff and provider at time of service. SRT option is Dragon front-end only with no editor role for transcriptionist.
- Perception that reduction in force/layoffs occurred at a faster rate than concomitant consistent decline in number of jobs/minutes in queue. We seemed to be on track with voluntary departures and natural attrition, but beginning May 2009 received mandated staffing level reduction notice that was non-negotiable.
- Loss of variety and subsequent loss of expertise in primary and specialty care transcription over time. Dictation that remains is confined to 35-40 physicians, occasional mid-level provider, and no more than five work types. Some dictators generate no more than a dozen reports per week.
- Morale issues which include perception that our work is non value-added, quality of work performed by some doing data entry is less than optimal (this is a work in progress), loss of employment with few job prospects in or outside of the field (general economy) and workflow that is not designed for productivity or quality of work experience for the work that we perform.

Cost Savings

Pre-Implementation Transcription Cost (includes staff and outsource company): 3.1 million dollars annually.

Post-Implementation Transcription Cost (includes staff and outsource company): 2009 budgeted as $500,000 annually.

ROI cost savings for HIM is not included in this case study. Schedule for complete elimination of all charts Clinic-wide is gone by March 2010. Current positions in HIM consist of Release of Information or scanning project or tasks.

Next Steps

- Organizational EMR focus for 2009 is enhancements based on provider/staff feedback. Prioritization determined by EMR Steering Committee and based on approved budget for 2009.
- ROI analysis currently underway for recommendation to purchase scheduling system module from current vendor; this would replace our current scheduling system and would likely be implemented in 2011 if approved.

Summary

The Everett Clinic is a successful, nationally-recognized physician-owned primary and specialty healthcare group. We focus on quality, value, and cost, with a strong emphasis on evidence-based medicine and outcomes. Our department has been very successful over time and fortunate to be included in planning and implementation for 2-3 dictation/transcription platform changes. After a lengthy and thorough process of investigation, analysis, and discussion, decision was made, and the vendor and product selected is considered the highest-rated EMR on the market. We did receive advance notice of the potential impact – a luxury few have, and particularly in today's economy. Our employer did its best to provide staff with information and resources in the past three years to provide assistance in transitioning to other departments or continuing education or help with resume and job searches should they opt to exit or be laid off as a result of a declining workload. Our personal experience was frustrating. We often received what was perceived as a mixed message regarding future job security but chose to remain with the hope the final department would be 7-8 employees handling an acceptable volume of what remained of dictation. The focus shifted from that to more pressure to reduce dictation and use 100% EMR tools for documentation, and providers who continue to dictate were encouraged to adopt the "Super MA" model (if staffing available) or use Dragon. Transcription staff members have been successful in the past 2-3 years in transfers to other departments, achieving reduction through natural attrition, or securing employment outside of the Clinic. We are currently fairly evenly split with half changing careers and the other half still employed doing medical transcription. Details as follows:

- 3 employees retired (Note: 2 were premature, as staff members indicated they would have preferred to work longer.)
- 1 employee accepted transcription position with another employer.
- Employees accepted subcontractor positions with our current outsource company. These MTs are still doing the same work they did as employees with the department.
- 4 employees accepted telecommuter subcontractor or employee positions with another outsource company.
- 1 employee transferred to Facilities Coordinator. Knowledge of Microsoft Office Suite and scheduling application. Strong customer service skills.
- 1 employee transferred to Surgery Scheduler. Direct contact with patients by phone or in person. Strong customer service skills. Data entry into scheduling system. Background in medical transcription/terminology is a plus.
- 1 employee transferred to Business Office Insurance Specialist. Strong customer service skills. Data entry into billing systems. Knowledge of variety of insurance plans required. Background in medical transcription/terminology is a plus.
- 4 employees transferred to Reception positions. Strong customer service skills. Knowledge of scheduling system, insurance plans, and provider schedules. Background in medical transcription/terminology is a plus.
- Other staff departures in the past 3 years related to non-return from Family Medical Leave, resignation, involuntary layoff, or other circumstances.

Transcription Planning for Reduction in Force

Most helpful to our department during the implementation was access to the complete rollout schedule. Rollout was done by department/site in small groups on a monthly to twice monthly basis depending on size of departments and number of providers, or departments discontinued some or all of their dictation. In addition, I contacted practice managers and physicians to ask specific questions about their workflow plans. There were some surprises: Providers we assumed would abandon dictation and adopt the technology sooner did not do that, and vice versa. I strongly encourage anyone preparing to go through a transition to EMR to request rollout schedule detail and timelines as soon as possible.

Transcription Process for Reduction in Force

Order of reduction in force when mandated by declining work or other factors:

- Elimination of temporary staffing
- Reduced outsourcing from two companies to one
- Reduced volume of work outsourced as staff able to accommodate workload and turnaround time needs without assistance.
- If involuntary layoff notices required, decision made by manager in consultation with Human Resources. Criteria included past performance evaluations, quality of work, computer/application skills, attendance, productivity, and years of service.
- Every attempt made to give employee 30 days minimum notice of layoff, though this was not guaranteed. We were able to follow this practice, including several more advance timelines for staff, particularly print/processing clerks.
- In May 2009, we were notified by Administration to begin further reduction in force at the rate of 1-2 staff members per month to achieve no more than 6.33 FTEs by 9/1/09. This decision was based on the estimated impact of continued rollout of Dragon licenses to those who continued to dictate, and further decline in workload. It was also felt to be budget-related for planning for 2010. Turnaround time and variation in workflow was handled by daily outsourcing company support. Some of the departures occurred because staff knew it was inevitable and they were able to secure other positions, so they stepped up to volunteer for next notice, sparing employees who did not have option at the time. Everyone in department did a remarkable job coping with the stress and uncertainty, and stepping up to support each other with compassion and teamwork throughout. Though some members of the department knew they could have continued to work 1-4 months longer, they exited when opportunities for more secure employment became available. This increased our outsourcing costs from $500 per month to over $4,000 per month, and daily outsourcing has been a feature at a rate of 50% of our daily volume as we are currently staffed with only 2.75 FTEs (full-time equivalent employees).

"Where Are They Now?"
Outcomes - 2007 to Present

Internal Transfers

- 1 employee transferred to Facilities Coordinator – Using Microsoft Office Suite and specialized software for scheduling maintenance and facilities remodel requests. Requires strong customer service and application skills.
- 1 employee transferred Surgery Scheduler –Use of scheduling system software. Direct contact with patients and clinical staff. Strong customer service skills. Knowledge of medical terminology is an advantage.
- 4 employees transferred to Reception - Use of scheduling system software, knowledge of anatomy/physiology and medical terminology skills is an advantage. Direct contact with patients and clinical staff. Strong customer service skills. Background in medical transcription is a plus. One staff member was print clerk only with no transcription or terminology skills.
- 1 employee transferred to Business Services Insurance Specialist –Knowledge of insurance plans and billing procedures. Direct contact with patients and others by phone. Data entry. Background in medical transcription/terminology is a plus.
- 3 employees retired, though 2 did so in advance of their planned departure and decision made to exit earlier and spare employment for co-workers. One retiree returned to work in HIM as a scanner, and is currently employed in Housekeeping/Facilities part-time.
- 2 employees accepted positions as subcontractors with our outsource company and continue to transcribe the same work they did as employees in Transcription.
- 4 employees accepted positions as employee transcriptionists, working from home for national company with primary accounts in our state.
- 1 employee returned to school while still employed in Transcription, completed recertification as MA, and transferred to clinical department. She is truly a "Super MA" which is a preferred model in healthcare groups with large EMRs. The CMA rooms patient and performs other required duties as an MA involved in direct patient care, but also handles the bulk of transcription into the EMR, allowing physician to spend little to no time "typing", which is a preference for many. Employment opportunities for CMAs are positive in the market in general.
- 3 employees remain in Transcription (1 manager, 1 full-time MT, 1 part-time MT).
- Other staff departures in past three years attributed to non-return from medical leaves, resignations, relocation, or other circumstances.

Other Comments:

Continued challenges for our profession for workforce development for successful transitions in sites implementing EMRs:

- Demonstrating value in documentation that includes narrative report content. Data that supports the enhanced accuracy and content of MT-generated documentation in comparison to general provider/staff data entry, in terms and reports decision-makers can relate to.
- Purchase and implementation of systems that are designed to truly support back-end SRT and other dictation/transcription workflows in an efficient, cost-effective manner.

- EMR development and standards continue to be a work in progress, making it more difficult to come up with revised curriculum for training and future workforce development for our industry. The technology is no longer in its infancy, so the prospect of a more unified effort to merge vendor and workforce in product development is possible as well as the possibility that competition and experience will lead groups to pool resources and negotiate for better products that more cost effectively include our professionals.

Based on our own experience and networking with others in healthcare, those who are already using EMRs, or planning to transition to full EMRs in the future, will be looking for employees who have a solid background in medical terminology, efficient and accurate keyboarding skills, and ability to achieve fluency in the system being used. The "Super MA" is highly prized by physicians fortunate enough to have them on staff. The switch to do-it-yourself documentation into the EMR has been difficult for physicians and clinical staff regardless of their knowledge of terminology. The CMA career path seems solidly positioned for growth and future job security. A medical transcriptionist fluent in terminology, medications, and keyboarding would have an added advantage.

As I review this document, I did lay out the reduction in force plan but would be guessing at the actual number of staff who exited in 2006, 2007, etc. so I think it generally shows over the 3-year period, what departures there were. I think we were very fortunate to have the timeline we did; very few would have that much lead time to prepare. It was also a mixed blessing as we basically all watched the queue and based our fears or optimism on whether the average # of minutes and jobs remained high enough to support the staffing level at any given time. It was like watching the New York stock exchange. You might blink and think it was your last day, followed by fear that you would not have enough resources to keep up with the continued volume. I definitely feel that there was sufficient time for staff to consider complete change in career path, continue to work, and attend school or take Clinic-offered classes to increase skills, but not related to the area of documentation specialist/transcription or HIM really – more for updating resumes, considering continuing education to move into clinical patient care/MA scribe role, Radiology tech, or HIM professional with advanced program.

With the exception of Reception and Scheduling which are enhanced by knowledge of medical terminology and keyboarding skills, all of the other positions were non-transcription, completely different jobs. To this day, we continue to observe and hear about Reception staff who absolutely need medical terminology as a basic skill set; they are entering reason for visit and continue to make careless errors, and clearly do not have the spelling or terms down. Example: "Rectal pollup" and others…They guess at spelling and there are some pretty glaring examples. Even clinical staff have struggles with correct spelling for terms though they may be excellent MAs or RNs. There are requirements for basic medical terminology for staff, but improvement is still needed.

I also hear about HIM employees who lack a more detailed knowledge of medical terminology, document types, etc., who are important in scanning, release of information, and other tasks. This is another area where a medical transcriptionist would excel over someone without similar background. Our HIM department would have liked to have acquired some displaced MTs during our downsizing, but the only jobs were either temporary or considerably less in pay and not considered good options for our staff.