



MedcomSoft Record™ : Implementing the Future of Medicine at Procter Family Health

*A case study in the digital transformation of a thriving family
practice clinic*

When Procter Family Health (PFH) opened its doors in McKinney, Texas, in August 2000, implementing an electronic medical record (EMR) was the farthest thing from Dr. Brian Procter's mind: "We started from scratch. I had more staff than patients, and there was only myself and my office manager." The practice, located in a busy, upscale shopping center, grew quickly, adding a nurse

practitioner, two medical assistants, and four front office staff. By June 2004, PFH's filing room held paper charts for more than 6,800 patients, and averaged 800 patient visits a month, split between the two providers.

"We were up and running with MedcomSoft Record™ in June 2004, and we were effectively paperless in seven days. By October, we were entirely paperless. Now each of my staff members does twice the work they were capable of prior to MedcomSoft Record."

The increased efficiency of workflow in the office is only one of the benefits Dr. Procter has seen from the implementations. In the first

quarter of 2004, the average patient charge at PFH was \$161.00. In the first quarter of 2005, that figure had jumped by 20 percent, to \$200.00. "The increase in patient charges is entirely attributable to the intelligent E&M coding engine in MedcomSoft Record. I'd thought we'd been doing coding reasonably well, so I was truly amazed at the charges we'd been missing." Just four months after implementation, PFH saw a 25 percent increase in charges and revenues.

"I've reclaimed 60 hours a month that I get to spend with my family and doing the things I want to be doing rather than charting."

Dr. Brian Procter

At MedcomSoft's demo: "This changes everything . . ."

In a market flooded by look-alike EMRs, Dr. Procter chose MedcomSoft Record because it alone has the capacity to manage all three critical workflows in a clinical setting: people flow, paper flow, and electronic flow. Dr. Procter saw this revolutionary potential at MedcomSoft's demo: "At some point, it might have been 2 minutes into the demo, I turned to my office manager and said, 'This changes everything. This even changes the way medicine will be practiced. Real time

information all the time.’ Now my small family practice can link to the world. I’ll see a headache in the morning, I’ll get a CT scan scheduled for 1:00 PM, the report is faxed back into the software, and I’ll see that scan before the end of the day. In the past, I wouldn’t have seen that scan for 24 or more hours. The same thing happens with labs: MedcomSoft is cutting 6-24 hours off results reporting.”

But perhaps the greatest benefit MedcomSoft Record has brought to Dr. Procter has been a vast improvement in quality of life:

“MedcomSoft Record has changed my life, literally. At 6:00 PM, Monday through Friday, I go home, and I’m done for the day. That may not sound earth shattering to most people, but before MedcomSoft, I’d take between 20 and 30 charts home with me in a big black satchel. Every night I’d put in 2 to 3 hours working on the charts. Now I use that satchel to hold workout clothes, and I use that time to be a father and husband. As a result, I’m a better doctor.”

Fully actionable point of care data collection: Value beyond traditional EMRs

Dr. Procter was not disposed toward EMRs out of residency. “I had a very negative attitude toward them as a result of what I thought were poor investments the institution had made in an EMR with what I considered to be very limited functionality.”

When he set up his own clinic, the idea of communicating electronically was so remote that his office’s technology infrastructure lacked the capability even for efficient email communication. “I had not even touched a computer in four years,” Dr. Procter says. In addition to his lack of comfort with technology in general, neither Dr. Procter nor his office manager saw a need for what a traditional EMR solution could do for them. “We were doing an excellent job of practice management,” Dr. Procter says, giving much

of the credit for this to his office manager. A former nurse and business owner, PFH’s office manager is ideally skilled to understand and anticipate the operational needs of the practice. The staff they built together is cross-trained, and all are responsible for performing multiple tasks. “Most offices have a staffer who does only referrals, but my check-out staff is so efficient, we don’t need one.”

Then there was the question of cost: “I thought I’d need a tremendous amount of capital to invest in an EMR—regardless of which I chose.” Why, then, did Dr. Procter seek out MedcomSoft for his practice? “I didn’t. It was recommended to me.”

Dr. Procter had spent several months establishing an indigent care clinic, and during that time he became acquainted with the professional in charge of setting up the clinic’s information technology systems. “One day he showed me a tablet PC—although I did not know it at the time, it was an M 1300 tablet, the model I use now in all of my clinical encounters. This IT pro recommended MedcomSoft to me as the best EMR on the market. He set up the demo and after that, comparison-shopping was unnecessary. I knew what I wanted and it was MedcomSoft Record. I saw immediately the advantages of having a truly paperless office, but more importantly I saw the tremendous benefits of the codified database technology that MedcomSoft Record offers. It improves performance in literally every aspect of what we do, from diagnosis and disease management to prescriptions and coding. I now have instant access to patient clinical information and an ability to ensure continuity of care for my patients when they are referred out to a specialist.”

While PFH was an efficiently run practice, all clinical documentation was collected, stored, and routed on paper. Because of that, its process efficiency, accuracy and profitability in the exam room, back office and front office, were severely limited relative to what is possible using MedcomSoft Record.

MedcomSoft designed and built Record on one key foundational insight: the central importance of clinical documentation to the way medicine is practiced today. The information generated between provider and patient at the point of care has become the focal point of the business of medicine. Orders, coding, and billing are all driven by clinical documentation. Surely there must be a better way to capture, organize, structure, and use clinical documentation than scribbling two-line hand-written notes on paper, then hours or even days later, translating those notes into a form to make them useful for billing and follow-up care.

Compare any EMR to MedcomSoft Record. Does it offer:

- ❑ Touch screen data capture for the entire patient encounter?
- ❑ Completely customizable and simple to format forms?
- ❑ The ability to order labs, imaging and prescriptions during the exam?
- ❑ The ability to analyze and review differential diagnoses based on 72 million possible data combinations?
- ❑ The real-time creation of justified, appropriate E&M coding?
- ❑ The automatic generation of narratives, without typing a keystroke?
- ❑ To enable a completely paperless environment?
- ❑ To increase revenue without adding to patients or payroll?

of their workflows. An ideal EMR would capture data at the point of care, ensuring accuracy and decreasing the rework involved

in transcribing notes later. Even voice recognition-based EMRs, mistakenly considered a panacea by many, do not provide clinicians significant efficiency gains. They are not point of care, and because they produce mistake-prone text, voice recognition's output requires time consuming review and correction.

Unlike traditional EMRs, which essentially replace file folders and nothing more, MedcomSoft Record is code-based. This single shift opens the door to a world of possibility that had only been suggested by healthcare futurists up to now. Record is based on Medcin®, the most comprehensive medical vocabulary available,

consisting of more than 250,000 numerically codified, clinical data points. These clinical data points have more than 72 million SOAP links between them, providing an unparalleled level of integrated intelligence and clinical decision support. Developed in collaboration with physicians from Cornell, Harvard, Johns Hopkins and other leading medical centers over the past 25 years, these clinical data elements ensure that practitioners can quickly and accurately document any patient encounter with clinically precise phrasing, using a "point and click" system.

Simply put, rather than hand-writing the symptoms with which your patient presents, MedcomSoft Record automatically generates a sentence of encounter narrative each time you click on a menu item. By automatically forming sentences and SOAP-related

Medcin®: A codified database makes all the difference

When the doctors who helped design MedcomSoft Record surveyed the field of available EMRs, they saw tremendous deficiencies. Traditional EMRs fall into two categories, based on the way they store information: Image based and text based. Both severely limit the way data can be used. Instead of becoming a tool to aid clinicians and their staff, traditional EMRs merely substitute one type of static data storage for another. Further, while traditional text- or image-based EMRs offer some workflow efficiencies to front office staff in terms of no longer pulling charts and handling paper records, clinicians themselves see relatively few benefits in terms

paragraphs based on the selection of data elements made during the patient encounter, Record instantly provides complete, concise, automatic documentation.

**Positive impact on practice patterns:
“I practice better medicine”**

Dr. Procter explains how using his wireless tablet PC affects how he works with patients in the exam room. “The only difference is that my patient visits are now simultaneously quicker and more thorough. That, and I walk into the exam room with a tablet PC rather than a clipboard. I log in with my thumbprint (patients like this), I hit the ‘summary’ button to familiarize myself with the patient, and in three clicks, and I have every important piece of information I need to treat that patient. The way the information is laid out on the screen helps me see a patient more comprehensively. I practice better medicine because of it. Record doesn’t think for me—far from it, but it does help me move more quickly and more comprehensively through the thought process leading to a diagnosis.”

“In less than six months I paid for the system 1-½ times in increased gross revenue”

Dr. Brian Procter

MedcomSoft Record’s screen layout was designed expressly for capturing patient information at the point of care. In fact, Record enables providers to document a clinical encounter in one-fifth the time it takes to create a text-based medical record. “Using the forms that have been built in to the software, doctors could be up and running, I mean working at the same or very close to the same pace as they had been, in an afternoon. Because I’ve customized the forms to match my practice patterns, I’m faster than the computer. I know which boxes to check and where they are screen to screen before the next screen appears. And keep in mind that I was not particularly computer literate when I left residency a few years ago.”

From the same data captured during the exam, MedcomSoft Record’s automatic E&M coding engine enables practitioners to instantly generate the proper code of virtually any documented clinical encounter, eliminating the need for staff time spent coding or for outsourcing this task. A practitioner is quite literally coding while charting patient information real-time, in the exam room. As

the provider enters information on one screen, Record displays on another screen exactly what steps in the encounter justify the billing levels it recommends. Simultaneously, Record alerts the provider of any missing clinical documentation items necessary to achieve appropriate coding levels. This feature prompts

clinicians to appropriately supplement the care, while the patient is still in the exam room. Once those items of documentation are entered into Record, the provider is assured of appropriate reimbursement.

According to Dr. Procter, “What takes me 30 seconds to chart in real time, as I see it, is far more efficient than the three minutes it would take me at home or in the office at the end of the day. And once you get behind in coding, you never catch up. That’s one reason why I took charts home every night. I’ve heard of clinicians who are as much as three weeks behind in their charting, and there is no earthly way that time lag does not affect coding adversely. Compound that with the fact that using handwritten, two-line progress notes corrupts the coding process. If you are only coding level-two visits all day long, you’re cheating yourself.”

But the reimbursement system itself creates the overly conservative approach many clinicians take. The fear of coding offenses among reputable healthcare providers is a real thing. The federal government estimates that at least a third of encounters are under coded, while other sources suggest that number is over 60 percent of encounters. By contrast, less than 10 percent are over coded. MedcomSoft

eliminates both problems by removing the cause for fear. MedcomSoft Record's comprehensive database takes the mistake-prone human element out of coding, ensuring compliance regulations and storing detailed justifications of coding levels to satisfy any possible audit. MedcomSoft Record allows the provider to override auto coding. "But," Dr. Procter says, "we do that less than 1 percent of the time, and it's usually to down code."

Smooth transition: Integrating technology into the practice

"After I saw MedcomSoft Record demonstrated, I knew I wanted it, but there were two potential obstacles for me: one was the question of capital investment and the other was the impact going paperless would have on my staff. If they would not support it, any investment I made would be worthless. First, I called a meeting with my staff to see if they would support it." The front office staff was supportive because of the sheer movement of paper they were dealing with, the chart pulling, misfiling. PFH's nurse practitioner, who had no experience with computers in general, was very supportive as well. The back office staff, however, was hesitant, and some of that hesitation had to do with a general apprehension around technology. The revenue benefits of MedcomSoft Record's intelligent E&M coding feature gave her the motivation to commit to the implementation.

And as to the cost? "I did not realize then that one could finance software. Cost has been no burden. I have a small monthly payment that's been offset by many multiples in terms of increased monthly revenues. By the end of the year—and I mean the end of the calendar year, so in less than six months I paid for the system 1-½ times in increased gross revenue.

Now every PFH employee has become responsible for documenting and exchanging information in every phase of their work. "We proved that anyone, regardless of background, could use MedcomSoft Record quickly and accurately. Our NP did not even own a PC

until four months prior to our installation of MedcomSoft Record. So on the day we rolled out the system, her entire technological background consisted of three months of tinkering with email. Now, she's about as adept as anyone. Just prior, we'd been in a fully paper environment, but if you watch the front office staff use Record now, you can't even see the cursor move."

With MedcomSoft, PFH was completely paperless and operating far more efficiently in just 45 days. Since the implementation, the practice has added over 1,000 new patients, without having to increase staffing.

MedcomSoft Record: What an EMR should be

The benefits of a paperless environment, in which data is captured real time at the point of care, cannot be over emphasized. Pulling a paper chart and managing the physical flow of paperwork around the office takes as much as 10 minutes per file. In fact, the Medical Group Management Association's research (based on year 2000 data) suggests that the average practice spends nearly \$13,000 per provider in traditional paper-based medical records costs. But the benefits of MedcomSoft Record far exceed increased efficiency in documenting and exchanging information. Dr. Procter knows this firsthand:

"I love it. My staff loves it. My patients love it. Often when I leave the patient in the exam room, I'm done with the encounter. Completely. The coding is done. The copay is taken care of. And I'm on to the next patient, as simple as that. With the improvements that have been made in the forms, I'd say most practices would be seeing benefits in the first day of using MedcomSoft. If doctors understood what they were seeing, they would leap at MedcomSoft Record. It will help any primary care, all general surgery and just about any specialty practice increase its revenue, do more with the same or smaller staff, and reclaim significant amounts of time."

About Clinical Transformation Management, LLC

Clinical Transformation Management, LLC is a consultancy specializing in satisfying the documentation, workflow, and reimbursement needs of clinics employing ten or fewer physicians. Through the integration of hardware, practice management software solutions, electronic medical records, and training, CTM offers an end-to-end solution to help you achieve your clinical transformation without compromising your patient care delivery process. We use an extensive competency in the market research of hardware, software, installation services and training to develop a customized process that generates the fastest possible return on investment, while remaining neutral in hardware product selection.

CTM provides small medical practices with complete, practical solutions, including

- Network Infrastructure Design and Installation
- Cutting-edge Electronic Medical Record and Practice Management Solutions
- Training and Support
- Medical Office Enhancement Coaching
- Ongoing Consulting Services

