



# SEARCHING FOR THE HOLY GRAIL

*By Mark A. Steele, M.D., Pediatric Ophthalmic Consultants*

## THE FACTS

- The EMR, a.k.a. EHR (electronic health record), has a high failure rate. According to industry experts, including David Brailer, the former Bush-appointed National Health Information Technology Coordinator, 50% of EHR implementations fail. Interestingly, most physicians who use EHRs cite the most significant benefit as having instantaneous access to patient records.
- The typical EHR requires significant changes in physician behavior. Any system that requires rigid data entry is prone to failure. Technology should make your professional life easier—not more tedious and difficult. The human conditions that we treat are complex. If you view the charts of your patients in any given clinic session, there are more exceptions to “standard” history, diagnosis, and treatment plans than there are routine encounters.
- According to a government-funded study by the MGMA and the University of Minnesota, medical practices report that the high initial purchase price and reduced productivity, combined with the lack of a reliable financial cost/benefit of EHR implementation, makes it difficult to establish a business case for EHR adoption. We make decisions every day founded on evidence-based medicine. Why would a physician adopt

a technology that has been studied and determined to have a relatively high probability of failure?

- An EHR system is an expensive proposition and according to the MGMA/University of Minnesota study, on average EHRs run 25% more costly than original vendor estimates.
- Even after the misguided economic justification for an EHR is made, serious operational problems remain. According to the same study, medical practices report decreases in physician productivity of up to 15%, usually lasting a year or more. If you do the math for your own practice, these numbers are daunting.

## MY PERSONAL QUEST FOR THE HOLY GRAIL

Eleven years ago, it was very apparent to me that my practice needed to go paperless. Multiple practitioners (now six pediatric eye MDs in our group) with multiple office locations coupled with the reality of expanding space requirements for medical charts at Manhattan real estate prices, made the quest for a paperless office a top priority. (My partners and I remember the awful “fly-by-the-seat-of-your-pants” days of taking phone calls from patients’ parents and referring pediatricians without the yet-to-be-found chart in front of us. We remember the satchels of charts that were being transported between offices and even to

\*This was a submission by Dr. Steele to an international pediatric ophthalmology listserv group to which he subscribes on May 1, 2008. This was written in response to other members discussions about creating an EMR for this specialty. This was reprinted with permission from the listserv administrator.



our homes to catch up on dictations and phone calls. We recall the countless, costly hours my frantic staff would spend looking for charts, filing charts, misfiling charts, assembling charts, archiving charts, faxing charts between offices, reading the chart notes to the doctors over the telephone, etc.).

We looked into working with an established EHR company to create an EHR system specifically for pediatric ophthalmology. As mentioned multiple times on this listserver, this is not feasible as our specialty is small and our records are unique. There is no significant incentive for an EHR company to expend the resources for this. We decided to hire the best minds to work within our office full-time to program an EHR. Initially, our only mission was to collaboratively create an EHR specifically for a high-volume pediatric ophthalmology and strabismus practice. After thousands of programming hours and beta testing of our EHR, as much as we wanted this to work, we realized that it was a failure. A fool's errand. The bottom line was that all the versions of our EHR required meticulous data entry. Drop-down menus, mouse clicks, and keyboard typing were all required to make a reasonable record. Plus, we still had the problem of paper. Referral forms, consult letters, superbills, EOBs, "back office" vendor bills, etc. The EHR was slowing us down. I was forced to see fewer patients. It disrupted our entire workflow. This technology became a burden and negatively impacted our bottom line. We permanently trashed the idea of a "data entry" EHR.

The solution became obvious—a hybrid EMR solution. We went back to the drawing board and SRSsoft was born. It works! Best of all, none of us MDs needed to change the way we practiced medicine. A new doctor to our group requires only 15–20 minutes of training to use the software.

So how does it work? The workflow starts at the front desk. SRSsoft merges with our practice management software by GE (it seamlessly merges with most practice management programs) and with all digital diagnostic equipment. The patients scheduled for the day and all their demographic data found within the practice management software are instantaneously merged into the SRSsoft schedule for each doctor for the day. With one click of the mouse, the entire day's paper is generated for a patient visit (encounter sheet, superbill, pre-printed spectacle and medication Rx sheets, ROS forms, patient registration forms), all with patient demographics merged into appropriate spaces and all with a unique small barcode at the top corner of each page.

The paper is placed on a stainless-steel clipboard and taken by a technician to an exam room with the patient. The encounter sheet is in whatever form you like. You can use your present encounter sheets and populate them with the date, patient name, DOB, referring MD/address, and any other demographic data desired. (Many users of SRSsoft simply dictate their exams, which are then transcribed and automatically imported into the patient's digital chart. The latest version 6.0 of SRSsoft also merges recurring meds, diagnoses, past surgical procedures, and allergies onto the encounter sheet).

A portion of the exam is completed by the tech and a portion by the MD or scribe using a pen (some SRS clients prefer tablet PCs to remain truly paperless). Most MDs will preview the digital record from previous encounters at a separate terminal before entering the exam room. We have terminals all over the office to give every staff member instantaneous access to any chart. When a pediatrician calls me, my staff no longer asks which patient the call is in reference to, but rather simply forwards the

call to whatever room I am in, and within seconds of typing in the last few letters of the patient's first and last name, I have the chart in front of me.

Our encounter form has numerous check boxes to document all the necessary components of the history and exam. A sensorimotor exam can be quickly jotted down on your encounter sheet, just as most pediatric ophthalmologists are comfortable doing. However, it is the motility exam documentation in all fields of gaze that will always be the nemesis of standard "point-and-click/drop-down-menu" type EHRs for strabismologists.

With SRS, all photos taken are effortlessly dragged and dropped into the patients clinical photo tab of the patient's virtual chart (all tabs are fully customizable). Motility photos in cardinal gaze positions are easily assembled into the consultation letter to the referring MD and are quickly available to help explain to patients and their families the details of the ocular motility disturbance.

Upon leaving the exam room, the clipboard's chart papers are then scanned at front desk with a high-speed scanner. Within seconds, each paper is routed to the appropriate tab of the proper patient file as determined by the barcode on each sheet of paper. No misfiling! At the end of the day, the papers are shredded.

SRSsoft is equipped with a robust office messaging module. Every message is linked to a patient's chart. The physician or staff member receiving the message can then type a response to the message if desired, or simply sign off. The message appears adjacent to the chart note as part of the patient's record. Telephone documentation and subsequent knowledge of the telephone message make for good medicine. The messaging module has a wonderful feature of "pooling" that allows for sending messages to a specific pool of staff members rather than individuals. Wherever we have an Internet connection, we have swift access to all of our patient records and messages. Three of the MDs in our group are full-time moms and part-time MDs. They easily log-in to the office from home at their convenience and without secretarial assistance, and they have immediate access to all of their patient charts, messages, transcription proofs, etc.

SRSsoft has complete e-prescribing capability and transcription template modules that make the burden of letter writing very manageable.

We receive all transcribed letters directly to the messaging module inbox attached to each patient's record (N.B.: When

dictating a letter, we only need to state the patient's ID # because the date, patient's name, DOB, referring MD address, and patient photo(s), along with our digital signature, have already been merged into a Microsoft Word document shell. (Microsoft has declared SRSsoft a "Gold Certified Partner," recognizing SRSsoft's quality, compatibility, and reliability)). After reviewing the letter and editing it directly in Word within SRSsoft, we then click a single routing button and the consultation letter is then printed by any staff member in the "printing pool" for that day. We also use a fax server that faxes letters and notes directly from the software. We will frequently e-mail consultation letters and pictures to patients' families effortlessly from SRSsoft.

The latest version of SRSsoft also has a "CliniSearch" feature for those of us who want to track certain patients with a variety of diagnoses. The software also complies with third-party-pay or "pay-for-performance" initiatives. There are many more bells and whistles within this software that simplify our professional lives, all without forcing physicians to become data entry clerks within a rigid EHR software application!

SRSsoft is now the nation's leader in hybrid EMR solutions. It is the paperless solution for many single-specialty and large multi-specialty groups. Many of our clients have had failed EHRs. The success of our award-winning software has been a result of direct doctor-to-doctor and administrator-to-administrator referrals. We now have a software development team of 18 whose work is directed by the SRSsoft clients. The software's evolution is commanded by the current users' requests.



The return on investment (ROI) for a hybrid EMR solution is rapid. Depending on which study you read, the cost of pulling a single chart from the chart room costs \$3.00 to \$5.00! The sense of calm in our office is remarkable. Everybody has access to any record at any time (even simultaneously). The staff have paperless desks. Peace of mind is priceless.

Our practice requires significantly less staff than paper offices. The doctors are empowered by universal access to charts and practice growth is assured without layering in more overhead to handle increased volume.

Although on the surface it sounds like a good idea for AAPOS members to universally agree on the structure of an EHR exam, this is a monumental task given the diversity of our practice styles and workflows. Although some doctors who are not concerned about reducing their current level of productivity may be happy with the end product, most would prefer a more customized solution for their unique practice needs. Furthermore, if a pediatric ophthalmologist in a group practice finds an EHR system that may suit his or her individual needs, the vendor who is willing to generate this subspecialty software may not be the preferred vendor for the other practitioners.

As we have offered numerous times in the past, our practice would welcome any site visitors to see first hand the workflow efficiencies made possible with our hybrid EHR solution.



## Pediatric Ophthalmic Consultants

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*York magazine's New York Metro Top Doctors in his specialty of strabismus surgery. He has served as president of the Greater New York Society for Pediatric Ophthalmology and Strabismus.*

*After graduating from the New York University School of Medicine, Dr. Steele continued at NYU as a resident in ophthalmology. He then completed a specialized fellowship in pediatric ophthalmology and strabismus surgery at the Wills Eye Hospital in Philadelphia, PA.*

*Dr. Steele is the founder of Pediatric Ophthalmic Consultants, the complex-strabismus consultant for the NYU Center for Craniofacial Anomalies, and the director of the Pediatric Ophthalmology and Strabismus Division at NYU Medical Center.*

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