7 MOST COSTLY MISTAKES

in Selecting Medical Office Software

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The biggest challenge with adopting technology is that even great technology doesn't live in a vacuum. Ultimately, its job is to make life better for humans in one way or another. And that means interacting with humans in ways that are natural, efficient and productive.

Because selecting technology is, well, a technology decision, the natural tendency is to focus on the tech: speeds, storage, features, modules, costs…In the process, major components of the primary objective — helping humans be more productive — gets overlooked. This is in large measure why so many tech projects fail on the first, second and even third try. The technology is functioning as promised, but the human interactions, processes, workflows and task requirements aren't clearly identified and incorporated into the solution.

Does the traditional paradigm for a technology stack of a Fortune 500 company mirror the needs of a small independent physician practice? This is certainly the case with medical office software. In fact, we have much to learn from the IT professionals at large enterprise organizations. Excellent technology applied in a vacuum or an environment of poorly clarified human needs almost always ends in costly work-arounds, fixes, endless integrations, or completely scrapping the project and starting over.

Guided by the experience of tens of thousands of medical office software installs in practices nationwide, we've identified the top seven most costly mistakes practices make in selecting their office systems. While there is obviously a technology thread that flows through the process, the most crucial points have to do with ultimately how you and your staff will interact with the system, and with your principle reason for being: patients.

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MAKING SPAGHETTI

To be effective, medical office software must simultaneously satisfy the needs of four significantly different groups within the practice whose technical and information needs and priorities differ, but who must all work together well in the end.

- Clinical/EHR
- Business/office workflow/scheduling
- Claims and billing
- Patient interface

Each group clamors for their specific piece of the solution with the specialized functionality and information that will maximize their effectiveness. This is not the problem. Each group's needs should be addressed in the new system.

The rub is that more often than not, no one is taking the global view of how it will all work together as an integrated system.

Instead, in our experience, the voices that carry the most weight – sometimes the doctors, sometimes the business people – choose solutions that may optimize a particular function, but end up creating additional unforeseen productivity barriers.

The result is a spaghetti of technical solutions that work well in isolation in meeting each group's specific needs, but often don't play well as a unified whole. Getting things to work even reasonably well together usually requires expensive consulting and technical integrations to glue it all together, which have their own set of optimizing limitations.

Then the finger pointing starts. The practice is upset and disillusioned by an expensive system that's not meeting expectations for productivity and cost savings gains hoped for. Vendors are backpedaling and gap-filling to deliver the best solution possible. And patients aren't getting the service they are increasingly demanding from their healthcare providers.

A classic example of this technical spaghetti is bringing in 'best-in-class' point solutions (e.g. EHR, telehealth or billing) from different vendors and expecting that they will all work in an optimized way. Even best efforts at working within common standards rarely deliver the seamless solution the practice envisions.

Keys to Avoiding This Mistake

Options for avoiding this common mistake include:

- Appoint a decision team member to specifically evaluate cross-functional impacts and integration before adopting any new technology
- Get the opinion of a vendor-neutral consultant specifically regarding the cross-functional question
- Work with vendors who have inclusive systems that cover multiple functions in a seamless, native environment

PATIENT-CONSUMER AFTERTHOUGHT

Today's patient is quickly moving to more of a consumer mindset with regard to their healthcare delivery. This is particularly true as more healthcare delivery services transition online and employ greater degrees of automation. Patients now view healthcare interactions through the same lens as other products and services they purchase. (Yes, Amazon is influencing your patient's buying habits and expectations.

This puts practices in an interesting position. Ignoring the trend and proceeding with business as usual ensures a slow drain of patients away to other practices more in tune with their needs. On the other hand, getting out ahead of the curve improves your ability to build a loyal and thriving patient base, but requires a fundamental shift in mindset.

Consumer-oriented organizations put the customer first and foremost in how they structure and run their enterprises, not as an afterthought shoehorned in after systems, processes and service delivery protocols are established.

This is the mistake that hamstrings many well-meaning practices who sincerely want to be more attuned to consumer-oriented issues, but find their hands tied by technology platforms that weren't designed or optimized with that goal in mind.

Patient First
A better process is to start the technology decision process with a patient-consumer mindset at the core, and include selection criteria that balance patient service with automation in each of the areas that maximize patient experience as well as efficiency and profitability.

Here's a quick example focused on new patient onboarding and scheduling. Simple, intuitive online patient-facing interactions are imperative, as is staff efficiency. New patients are directed to a patient portal where they are presented a customized set of onboarding intake and consent forms that are simple to complete online anytime of their choosing, including on a mobile device. Online help buttons for most frequently asked questions are readily available, as is a daytime chat function.

On the back end, staff select the appropriate forms required for each particular patient situation from a library and drop those forms into the patient's portal. Automated reminders (text, email, multi-language) help patients complete their part prior to the visit. Once completed, key information from the forms automatically populates the patient record and chart. Scheduling integrated with the live office calendar allows patients to change/reschedule their own appointments from their portal without staff intervention and lengthy phone interactions.

Keys to Avoiding This Mistake
This type of functionality is available throughout the patient journey when deliberately planned in advance and designed into the technology decision process from a patient-consumer mindset. Retrofitting almost always results in lower satisfaction and higher cost for both patient and staff.

- Assign a decision team member as the designated patient-consumer to test all functionality being considered from that viewpoint.
- Stay abreast of patient-consumer trends being implemented at forward-thinking practices.

FLYING BLIND: REPORTING & ANALYTICS

Donald Rumsfeld is credited with this classic insight into our field of understanding in any endeavor in life:

> *"There are known knowns. These are things we know that we know. There are known unknowns. That is to say, there are things that we know we don't know. But there are also unknown unknowns. There are things we don't know we don't know."*

The unknown unknowns, the things we don't know that we don't know, are the most dangerous, particularly if we don't acknowledge that we have these blind spots. You know you've hit one when you say, "I had no idea that was possible," when someone shares an idea they've known for some time.

This phenomenon is at the heart of this mistake, because practices don't know what they don't know about data, reporting and analytics, and get locked into systems that are totally incapable of delivering the tremendous potential value they discover when they come to know what they didn't know they didn't know.

It's actually very predictable. Smart practice owners are focused on the functionality they need in each of the four areas to deliver service and control costs, and don't realize that unlocking the greatest potential gains long-term is dependent on data and analytics.

Here are a few of the blind spots. Many practice owners are unaware that:

- Data insights and visibility trump 'gut feel' every time.

- Data-informed decisions are best for the patient experience and the practice

- Data analytics isn't just the purview of large organizations

- Data analytics isn't some type of 'big brother' activity. It's actually best practice.

- Very few systems come with this capability out of the box

- One of the greatest inhibitors is simple access to unified data across functions

Here is a quick example: Utilizing data analytics from a unified database of your practice, identify highest volume and highest profitability procedures. Match these with demographic growth data for new patients joining the practice, and you are able to offer valued services to an expanding population that maximize both patient satisfaction and demand as well as practice profitability. On the flip side, you are able to identify procedures that are unprofitable, and take steps to reduce costs or refer out.

Unfortunately, adding this type of functionality after the fact isn't easy or inexpensive, and more often than not, is just not available.

> *"There are known knowns...There are known unknowns... But there are also unknown unknowns..."*

Keys to Avoiding This Mistake

Avoid this mistake by assuming that you are a great clinician or administrator but probably have a large data analytics blind spot. Work with experts to identify the types of insights and outcomes you are interested in (or possibilities they suggest) and then find systems that can support those.

The two key components are: **1)** unified database across all practice functions and **2)** strong data analytics engine native to the system with simplified report generation capability.

NON-UNIFIED WORKFLOW

Chaos is the enemy of process. The healthcare delivery

process is complex, personalized and highly exacting.

Because of that complexity, many practices find themselves struggling with chaotic workflows and technology systems that seem to defy their best efforts at standardizing and optimizing.

This mistake is typically rooted in two factors:

Independent, silo solutions.
This is an outgrowth of Mistake #1. Functional systems that weren't designed to easily share data, handoffs and process components create barriers to automated workflows that on paper are easy to outline, but in the technology stack become impossibly difficult or expensive to deliver.

Dashboards and task management.
Even with data and handoffs flowing between functions, the sheer volume of details can overwhelm both human and technology capacity. A crucial part of an optimized workflow is knowing who is doing what when, and prioritizing tasks and workflows so that crucial elements are always consistently covered. Trying to bolt on this capability in retrospect is rarely successful.

Taking this capability to the highest level includes dashboards with graphical features (dials, donuts, graphs, color-coded alarms, etc.) that allow providers and staff to manage complex tasks and large volumes of data at a glance.

Keys to Avoiding This Mistake
The keys to avoiding this mistake include selecting systems that:

• Are designed and built as an integrated whole,
  not separate components

• Share a unified database easily accessible to all functions

• Include pre-built common workflow and task management
  functions that can be tweaked to specific needs

• Include simple-to-use pre-built graphical dashboards for
  specific responsibilities within the workflow
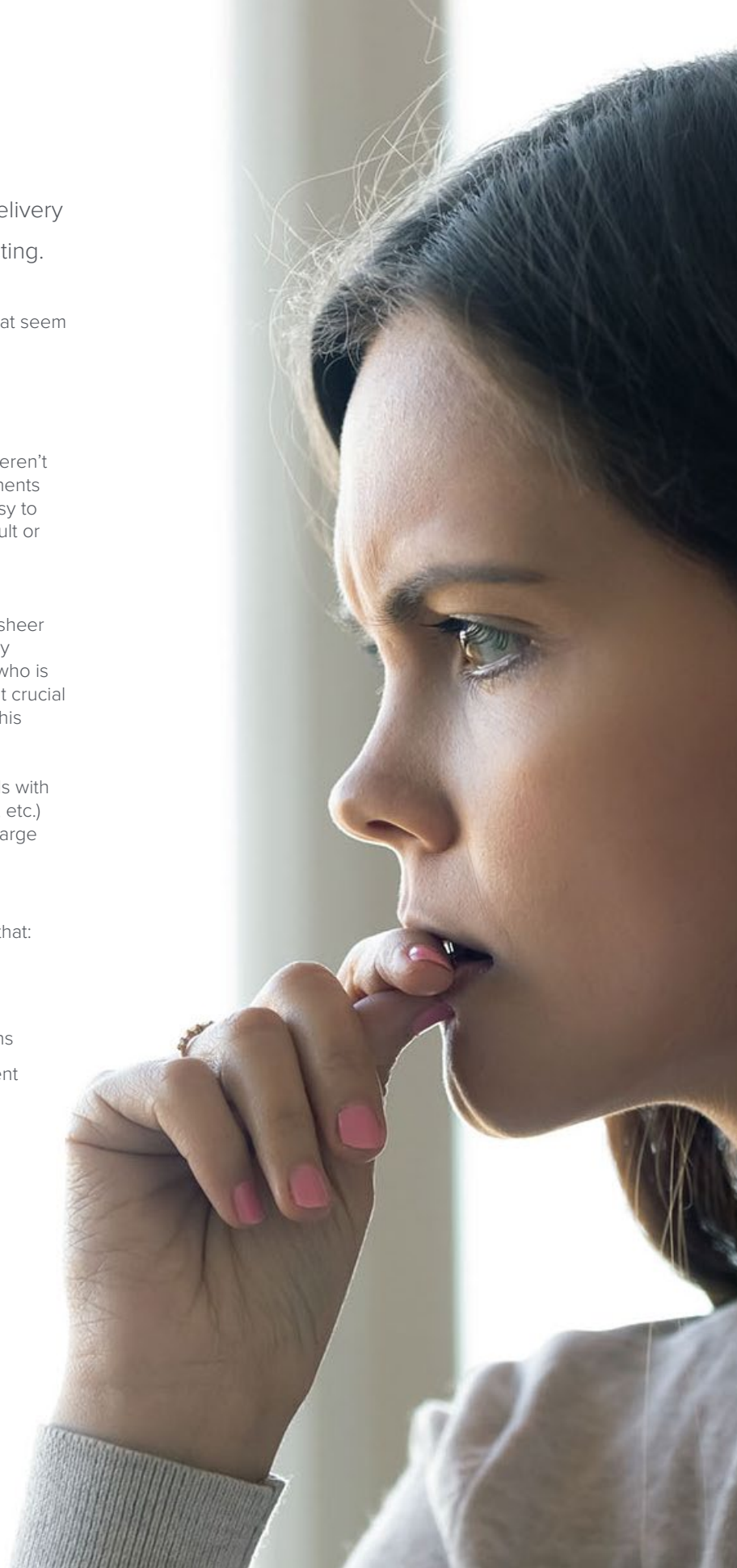
OOPS, HOW DO WE SUPPORT OUR NEW LOCATION?

Practices looking to optimize success in the 'new normal' world of healthcare delivery in the future will want to have as many options open to them as possible.

This may include remote delivery options like telehealth but could also encompass physical practice expansion or acquisition/combination.

Many practices commonly assume that technology running well in their office can simply be replicated to a new office or location. While this is partially true – with regard to the actual on-site functions – it often doesn't translate to multi-site management, data transfer, reporting and workflow sharing.

This mistaken assumption is most damaging to the heart of the expansion in the first place. The synergies of higher volume, potential shared functions, services and workflows the practice envisioned often evaporate because the technology platform is incapable of supporting the complexities of multiple locations and providing the reporting and business controls and insights that make for a viable expanded operation.

For example, a subtle nuance that over time pays big dividends is instant data sharing over a common system between all locations. Let's say a practice expands to locations A and B, and decides to consolidate billing in location C. A billing expert in location C notices that patient Smith is behind on payments, hasn't responded to multiple messages, and through the unified calendar finds that they will be visiting location A the next day. The biller creates a task reminder for the checkout staff on duty that day to have the financial discussion with patient Smith before they leave the office. The reminder appears at the point of service as the patient checks out. The results of that encounter are reported back through the same task management system.

Keys to Avoiding This Mistake

System selection criterion must include the ability to efficiently manage scaling up to future potential multi-site growth in each of the four areas, as well as maintaining unified, global reporting, workflows, data and analytics.
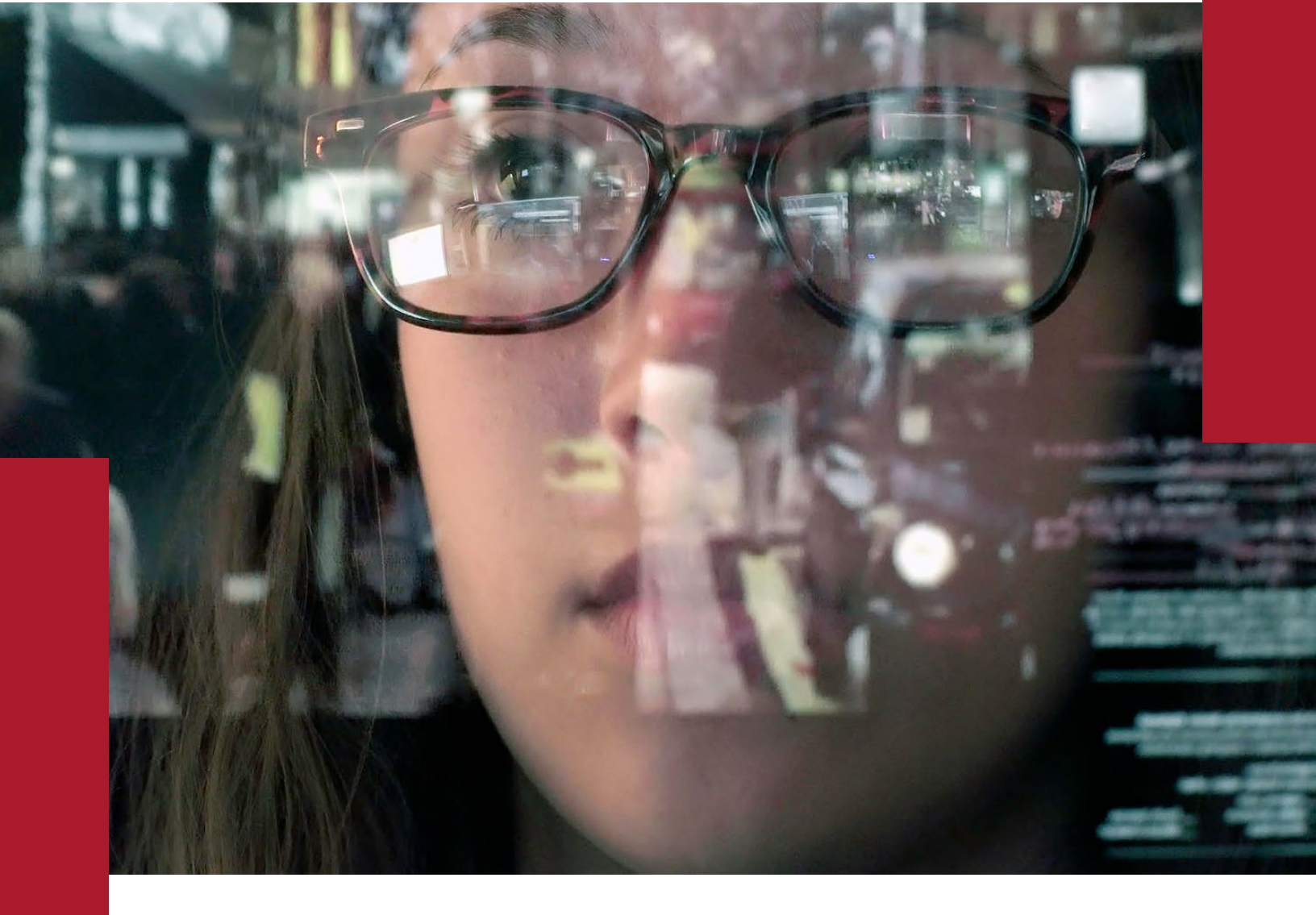
HEAD IN THE CLOUDS

With all the talk of cloud technology these days it's easy to quickly get lost in the jargon and details. So, practice owners default to a 'cloud-based' check box in the medical office software decision matrix. Which is fine. They aren't expected to understand all the details and technical specifics of cloud-based systems.

The mistake is in not understanding that cloud-based doesn't always mean truly cloud-based. It should, but it doesn't. Here's why: some systems were built before cloud technology was broadly available, fast and secure. They were built as onsite, server-based systems. When cloud technology moved mainstream, these systems were 'converted' to run on the Internet. Converted typically translates to a series of compromises, patches and workarounds to make every run online, while still giving the user moderately acceptable access to key information.

The result is you have a system running in a cloud environment it was never actually designed for. Which causes performance issues, data sharing and transfer issues, and feature limitations, particularly with online, interactive capabilities that patient-consumers are increasingly requesting.

Going into more detail on cloud technology here will defeat the purpose of keeping it simple and actionable. For those who care to delve deeper, click here for a detailed cloud technology backgrounder.

Keys to Avoiding This Mistake
The most important thing to discover is whether the system you are evaluating was developed as a 'native' cloud application, or if it was converted from a site-based (server-based) system. A few specific things you can check:

- Ask the vendor point blank and have them share the software development history of the application. The pedigree may include pre-cloud technology components and acquisitions of companies who brought their own history and pieces of the puzzle to the party.

- Watch and compare demos of the more mobile, interactive pieces of the solutions you are considering, like mobile charting, prescribing and ordering for providers and mobile patient interactions for patient-consumers. This is where the limitations in non-cloud-native technology will show up most noticeably as potential red flags.

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ALL BILLING IS NOT CREATED EQUAL

Claims and billing automation has been around so long in the healthcare industry that for many practice decision makers it has become a checkbox item as long as it provides all the core features of billing and getting paid.

Many practices get hemmed in with systems that perform the basics well, but don't allow for advanced, integrated features and workflows to be added as the practice matures and continues to optimize. Here are a few examples of advanced features that would be out of reach to a practice who opted for a bread-and-butter claims and billing solution:

Payer-specific, continuous claims experience updating.
This is partially a function of a cloud-based system that allows a vendor to learn from the rejection experience of other providers, make payer-specific adjustments to its code to achieve acceptance, and share that knowledge across the network of providers in the form of a continuously updated system. This type of progressive sophistication delivers first-pass clean claims acceptance in the high 90s percent range – something you should expect from any vendor today.

Automated account posting.
When patients pay online through a patient portal or an online bill-pay portal, the patient account is automatically updated, saving hours of billing staff time doing manual posting. Payments can trigger a stop to sending automatic bill-pay reminders and soft collection letters.

Automated charge slip (superbill).
When a provider finishes a visit, the coding information transfers directly from the EHR system to the billing system without human intervention, reducing manual processing and potential errors.

Data analytics.
The ability to quickly and easily cross reference coding, claims, payer, procedure, and other key information in the billing system with demographic, diagnosis, payment and scheduling data from other areas is crucial to moving beyond entry-level optimization to significant gains in efficiency, service and profitability based on deep data insights.

Keys to Avoiding This Mistake
While the assumption is generally true that core claims and billing functionality is fairly standard across vendors, avoid the trap of thinking that virtually any system will meet your needs. Instead, look for systems that employ innovative functions that integrate with other critical workflows in the practice, including with patient and data and reporting functions. Expect extremely high levels of performance based on years of success across thousands of users.

Also keep in mind that innovation and ease of use tend to be core values a vendor either espouses or ignores. Vendors who have been at the forefront of claims and billing innovation over a sustained period are likely to keep providing new, leading-edge options that will keep you from getting boxed in as the industry and your own practice capability move to the next level.

SUMMARY

Medical office software in general has matured to the point of offering solid performance in the major functional areas that make up a successful practice workflow. Practices get into trouble by not understanding the types of technology platforms and cross-functional features that will allow them to easily innovate and optimize for many years into the future as they and their patient bases mature together in the emerging healthcare delivery landscape.