Case Study

MediNotes in Practice

One Physician's Journey Into Automation

By Richard H. Blau, M.D., F.A.C.R.

As a rheumatologist, I see some patients as frequently as once a week at the Arthritis Institute of Long Island®. A single patient encounter, consisting of office notes, X-ray reports, lab results, flow sheets and correspondence, can generate 10 to 15 pieces of paper. One patient can easily have 500 pieces of paper added to her medical chart every year.

On average, the practice generated 1,000 and 2,000 pieces of paper per week, and I spent two to three hours a day dictating notes for transcription. I am a solo practitioner, yet I had 21 full-time and part-time employees because of the nature of my practice.

EHR With Document Imaging

In April 2003, I purchased MediNotes e, an electronic health record (EHR) computer system by MediNotes Corp., to minimize dictation time and decrease my dependence on transcription. The EHR had integration capabilities with a medical records document management system, V-chart. Part of the reason I purchased the EHR was the price value, along with the ability to purchase V-chart as part of the system. We installed the EHR in May 2003.

We use other software products, too. PhonePad is used for intraoffice electronic phone messaging, and SnagIt captures the telephone printout from PhonePad in a TIF format, which gets directly imported into the system and becomes part of the patient's record. ZetaFax provides computer faxing capabilities and integrates with MediNotes e and V-chart, allowing us to fax directly from either program. I can speak with another a physician about a patient's lab tests and fax him the lab tests from my computer while we talk.

We no longer mail laboratory test results or office visit notes to physicians, but fax them directly from V-chart, which saves us considerably on postage. A copy of the fax is automatically saved into the patient's medical record for documentation purposes. Incoming faxes are electronically received by ZetaFax, imported into the document management program, then electronically filed into the patient's chart.

Utilizing a document management system with an EHR lets me store every piece of patient-related paper in my computer system. I can retrieve a patient's entire record from a PC while seeing the patient in any of my five examination rooms. I don't have to rifle through pages in a chart to find an intake sheet, lab report or telephone message. I look at the computer and everything is there at my fingertips with a few mouse clicks.

Implementing the new system has changed the dynamics of my practice, and my life, for the better. Overall, we have decreased our administrative payroll by about 40 percent. Together, MediNotes e and V-chart have helped eliminate paper from my practice; today, we are 95 percent paper-free.

One of the biggest helps of this system is having access to all of my patients' records in the privacy of my home. I installed a secure, HIPAA-compliant virtual private network connecting my home to the office. The secure tunnel allows me to pull up the patient's entire chart at home if I receive an after-hours call from a patient. I have access to that patient's complete record, including his photograph, which brings to mind his last office visit. When the patient begins explaining the problem, I can view his entire chart and know exactly what I am dealing with.

Big ROI

The entire software system cost less than $12,000; it paid for itself within months and in the time it has saved me personally. Many physicians talk about saving time and money, but until I experienced the savings for myself, I didn't realize what automation could do for me.

I save at least two to three hours a day in dictation time and have reduced my dictation time to 15 minutes daily. I have eliminated at least 20 hours a week of dependence on a transcriptionist.

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I also save at least 10 hours a week by not having to deal with office visit notes. Office notes are completed at the time of the patient visit. By the time I leave the exam room, my note is complete. Everything is legibly recorded and signed off on electronically. If I refer a patient to another physician, I can fax my office note to the physician from the examination room, before the patient leaves.

PhonePad allows us to integrate electronic text messaging into the system and eliminate pink phone message pads. Staff members send a text message directly to me, in real time, with patients' questions about lab results, blood work or prescription refills. I respond in text, and the phone message is tracked electronically. No one has to pull a paper chart; my staff get their answers quickly, and we have an audit trail of all incoming and outgoing messages.

We don't use a copy machine, and we have no paper, no toner or no toner drums. With ZetaFax, we have eliminated the fax machine, and have no more fax paper or fax toner. Records are printed or faxed from the desktop computer.

Prescription for Efficiency
I also save time using MediNotes e to write electronic prescriptions. Within a month of purchasing it, I began utilizing the electronic prescription function for all the scripts in my practice. Two clicks of the mouse while in MediNotes e, and in two seconds, a typewritten prescription is printed and waiting at the front desk for the patient when he leaves. Or, if the patient prefers, the prescription can be directly faxed to the pharmacy from the exam room.

I have not received one call from a pharmacy in eight months to clarify an electronically generated prescription. In addition, the patient's file is updated in the system in real time to reflect the written script. If the patient calls back with a question soon after she leaves the office, updated information is available to the front desk with a mouse click. This has been a real timesaver, especially in responding to patients with multiple prescriptions.

We will add a laboratory information system next month that will allow all of the patient's laboratory tests performed in our office and the reference lab to go directly and instantly into the patient's chart. This information can be imported directly into the patient's office visit note.

Also, within the next several weeks, we will add an integrated billing system so that when I order a test, it will go directly into the billing program. This will eliminate the need for both a superbill and someone to batch enter the billing the next day.

Intrinsic Benefits
When factoring in the intrinsic value of the system, the actual return on investment becomes harder to quantify, because there have been so many improvements at so many levels.
In less than one year, these different systems have together changed the dynamics of my practice. My employees have more enjoyable jobs and improved morale. They enjoy using the electronic system rather than pushing paper. They can respond to telephone requests more quickly because they can access patient records from the desktop without leaving their workstations.

Patients have said how impressed they are with our high-tech office. They can see firsthand in the exam room that we have their vital health information at our fingertips. They receive answers immediately when they call in with questions, instead of waiting several hours for a return call.

I make a distinction between the practice of medicine and the medical practice. The subjective and objective findings regarding a patient's medical condition are simply pieces of information. Patients' complaints, vital signs, allergies, chest X-ray results and lab results are all pieces of information. Computers are built to handle information. The procedures of storing and retrieving this information are part of the medical practice.

It is what a practice does with information that constitutes the practice of medicine. Putting large amounts of information into a manageable form helps me to practice medicine more efficiently—for patients and myself.

Richard H. Blau, M.D., F.A.C.R., is the medical director and founder of the Arthritis Institute of Long Island

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