

Chapter 11
AC Group's 2007 Annual Report
The Digital Medical Office of the Future
Performance

A. Methodology

The majority of previous EMR evaluations have been limited to self-reported functionality. Although high rankings in this arena often indicate a superior product, the reviewers are aware that in some cases this correlation does not always hold. There may be some highly ranked products offering the full range of functionality that from the end user's point of view may have features, organization or display that are limiting. The converse may also occur where a product that achieves a lower ranking because it offers less than full functionality nonetheless offers highly innovative features that would be advantageous for all end users. In short, although scores from self-reported functionality are extremely useful, they do not capture rich qualitative information that could significantly influence the practitioner's decision of which system to choose.

The purpose of this document is to help a physician evaluate a vendor's solution. The document is divided into separate product demonstrations. If the practice is interested in one fully integrated system, then have the vendor complete and interact with this entire document. If the practice is only interested in a Document Image Management solution, complete sections B and D. If the practice is only interested in a comprehensive EMR/EHR application, then complete sections B and E.

Speed is essential

Time the execution of the tasks and record how long they take. You may be surprised at the significant difference in the results. Speed is extremely important during physician documentation.

Screen Changes must be low

When evaluating a system, compare how many different screens are presented to accomplish a task. Studies have shown that fewer screen changes improve performance and reduce eye movement regarded to adjust to the new screen. For example, one EMR vendor only requires 3 screens to record a physician note while another requires 32 screens.

Pop-up Screens must be low

Think about all of those pop-up that appear when you are on the internet. After awhile, you just wish they would go away. Some vendors incorporate too many pop up screens during data entry. Every time a pop-up appears, the clinician must adjust their eyes to the location of the pop-up. In most cases, these pop-up are located in different locations on the screen. Many times, the pop-up blocks required information that is located on the main screen. In 10% of the cases, the pop-up blocks the patient's name. Consider vendors that have lower pop-up screens.

Click-O-Meter must be low

The Click-O-Meter is a measure of how many mouse (or stylus) clicks, text entries and other actions must be taken by the user while digging down into the system, in order to accomplish a task. Extensive research has shown that most users won't use (or won't want to use) any task with a Click-O-Meter score above 3. During the demonstration, record high Click-O-Meter scores.

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Level of integration

A number of vendors state that their products are interfaced and sometimes integrated. However, what does all of this mean? I would recommend asking them in order presented, which highlights the differences:

- **Single database** refers to where all components share a common database - first, on the same database product, second, in a single, unified database.
- **Integrated** means that the two systems work together in a manner that is transparent to the user. That is the user just does their work and does not worry about or know about the plumbing that makes the two systems work together.
- **Interfaced** refers to the fact that there are mechanisms in place to allow the two systems to work together, although it may entail intermediate steps, including but not limited to one or more of: exporting, translating, transforming, importing, massaging, cleanup.

Demonstrating a typical practice-specific scenario

When considering an EMR/EHR selection, each vendor should be asked to complete a practice specific scenario. The scenario should be based on a routine patient seen by the practice. For example:

Workflow

- Document how to send a message about a patient to another provider
- Show how a medication is refilled.
- How are scanned documents, faxes and transcription handled

Documentation

- Document a full patient visit from check-in to check-out
- Show how new terms and knowledge are added during the visit
- Sign off on chart and then make an addendum.

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Detailed Documentation

A practice can also add a more detailed scenario for the vendor to complete. For example:

- ❖ 55-year-old female with rheumatoid arthritis, osteoporosis, returns for a 3-month follow-up visit in rheumatology clinic. She is on combination therapy with methotrexate 15 mg/wk, azulfidine 1500 mg/day, prednisone 5 mg/day, alendronate 70 mg/wk, folic acid 1 mg/day, viox 25 mg day. She has a swollen R knee requiring joint aspiration and injection with 40 mg depo medrol. ROS is positive for dry eyes, R knee swelling, and dyspepsia the latter of which will lead to referral to gastroenterology.
- ❖ 41 y/o w/f presents with daytime sleepiness and restless legs. She is a loud snorer and has witnessed nocturnal apneas. She has a bedtime of 10 pm and a rise time of 7 pm. She drinks 3 coffees daily. She does not abuse drugs or alcohol. She has hypertension but no CHF.

Allergies: Sulfa drugs

PMH otherwise notable for: DM type II

Narrow angle glaucoma

Meds: Glucophage

Hydrochlorothiazide

Social history: Married. Nonsmoker.

Family history: 3 children AAW Brother with hypertension

ROS: Dysuria

Recent hemoptysis

Physical Exam: BP 140/85 HR 70 Temp 100.4 RR 20 Wt. 245 Ht. 5'3"

Skin neg

HEENT: nasal turbinate hypertrophy, large tongue and uvula

Chest clear

Cardiac exam: neg

Abdomen: obese

Extremities: no CCE

Neurologic: neg

LAB: CXR 4 cm. RLL mass

UA: positive for 45 WBC/HPF, GNRS

IMPRESSION

- ❖ RLL mass and hemoptysis probable bronchogenic carcinoma
- ❖ Hypersomnia, snoring, witnessed apnea. Probable sleep apnea
- ❖ Restless Legs Syndrome
- ❖ UTI
- ❖ Narrow angle glaucoma
- ❖ DM Type II
- ❖ Obesity
- ❖ Sulfa allergy
- ❖ Hypertension

PLAN

- ❖ Chest CT with and without contrast
- ❖ Bactrim DS 1 bid for 7 days
- ❖ Mirapex 0.125 mg. 2 hours prior to bed
- ❖ Sleep study

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EMR: PEDIATRIC CASE

CC: 5yo boy with Trisomy 21, with wheezing x 3 days

Person who brought child: mother

HPI: 5yo boy with Trisomy 21, with hx of asthma in past, now with night cough for 3 nights, and wheezing in day time x 3 days. Had URI symptoms one week prior. No fevers. +seasonal allergies in spring. Mom has only given him cough medicine, she had not resumed his asthma meds.

PMHX: Allergies: PCN

Meds: sythroid: 125mcg q day

Xopenex 1.25 mg nebulizer q4-6 prn wheezing (not receiving it currently)

Pulmicort 0.5 mg BID (not receiving it currently)

PMHX: Trisomy 21, asthma, seasonal rhinitis, recurrent otitis media, VSD, Intestinal obstruction, neonatal blastocytosis and thrombocytopenia, speech delay (signs only), feeding problems: eats soft foods only, dental decay, hx of aspiration pneumonia, hypothyroidism

PSHX: VSD surgically repaired age 1

Intestinal Obstruction age 6months: repaired

Bronchoscopy: age 4

Circumcision: newborn

Development:

Hypotonia: Trisomy 21

Sat: age 1 year

Walked: age 3 years

Verbal: signs only

Immunizations:

DTAP: 2,4,6, 15months, 5 yrs

IPV: 2,4,15 months, 5yrs

COMVAX (HIB and HEP): 2, 4, 15 months

MMR: 12 months, 5 years

Varicella: 12 months

Influenza: Nov, Dec 2003 (fluzone 0.25cc each)

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EMR: Peds case page 2:

Vital signs: Wt 40 lbs, HT 40 inches, Temp 101 BP 80/60, HR 120 RR 40

Pulse ox: 92%

Growth chart: needs to be plotted on Downs Syndrome growth chart

PE: Gen: ill appearing, anxious child with Trisomy 21 and mild respiratory distress:

HEENT: head: microcephally with upslanting palpebral fissures

Ears: bilateral red bulging TM's

Nose: thick purulent green mucous discharge

Throat: no erythema, +tooth decay

Lungs: tachypnea

Poor air movement with tight wheezes

Heart: mild tachycardia, no murmur, no rub , no gallop

Midline scar on thorax

Cap refill less than two seconds

Abd: large surgical scar

BS+ soft without masses

No hepatosplenomegally

Ext: hands: short metacarpals and phalanges

Hypoplasia of midphalanx of 5th finger with clinodactyly

Simian crease bilaterally

Back: no scoliosis

GU: small penis. Tanner 1

Dev: mental retardation

Developmental delay

Speech delay

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EMR: PEDS page 3:

A: Asthma exacerbation, respiratory distress
Otitis Media
Trisomy 21 with hypothyroidism

P: In office: given at 1030am: Xopenex 1.25 mg nebulized with oxygen.
Pulse ox repeat on oxygen 98%

After Xopenex, repeat lung exam: improved air movement, more bilateral wheezed noted. Pulse ox on room air: 93% VS Temp 99 RR 30 HR160

Given at 1100 am: Repeat Xopenex 1.25mg nebulized with oxygen.
Pulse ox repeat on oxygen 98%

After xopenex, repeat lung exam, improved air movement, looser wheezes noted, pulse ox on Room air: 95%
Temp 99, HR 175, RR 24

Given at 1130am: orapred: one tsp (15mg) po in office

At 1130 sent to Xray: CXR reading by me: no infiltrates, + hyperexpansion with flat diaphragms to 10.5 ribs. Pulse ox 95% room air, temp: 99, RR 24 HR 120

Disposition: mom feels comfortable taking the child home because she has home nebulizer. Mom requests med forms for school.

Asthma plan given: Xopenex 1.25mg unit dose via nebulizer every 4-6 as long as coughing or wheezing.

Pulmicort 0.5mg unit dose via nebulizer BID

Orapred: one tsp per day x 4 days.

Amoxicillin: 250mg/5cc: 2 tsp po TID x 10days

** need to generate printed asthma plan with red/yellow and green zones

tell parents, after child stops coughing, will continue pulmicort Bid for at least one month.

Is HMO need referral for f/u hypothyroidism: peds endo, f/u blastocytosis: peds hematology, needs dental f/u. Needs CBC, free T4, TSH levels.

Follow up: Re check tomorrow in clinic at 1000.

Comments about EMR needs for this PEDS case:

- ❖ Downs syndrome growth chart is needed.
- ❖ (For most other peds patients the gender specific and age specific growth charts : Boys birth 0-36 months, Boys 2-18yr and Girls birth 0-36 months, girls 2-18 yrs 2001 (with BMI's on back) <http://www.cdc.gov/growthcharts>)
- ❖ Immunization records from prior years needs to be entered, as well as lot # etc
- ❖ Asthma plan and medication form for school needs to be generated
- ❖ Order for labs and xray needed to be generated in lab/xray section
- ❖ Order for meds needs to be generated to pharmacy
- ❖ Order for amoxicillin used to be calculated on 40mg/kg now the current recommendation is 80-90 mg/kg
- ❖ Acute visit template
- ❖ Area to add in nebulizer treatments, pulse ox and repeat or serial physical examination
- ❖ billing coding generation:
 - 99214 Level IV office visit
 - 94640 Nebulizer treatment

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94760 Pulse ox
94664 Instruction for nebulizer

❖ nebulizer administration set

❖ If HMO patient, needs referral for f/u ped endocrinologist (hypothyroidism), f/u peds hematology referral

(12) would need ability to see past lab results for CBC and thyroid studies.



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Neurology Progress Note

- Established Patient
Level 3

Problems

Complex partial seizures
 Carpal Tunnel Syndrome
 Deep Vein Thrombosis

Medications: Lamictal 150 mg po bid, Keppra 750 mg bid, warfarin 5 mg po qd

Allergies: Penicillin, Tetracycline

Interim History.

She has had 3 seizures since the last visit. All are generalized seizures with tonic-clonic activity. All were associated with tongue-biting and urinary incontinence. Since the last visit she developed DVT in her right leg. Dr. Jones, her primary physician, has started her on warfarin 5 mg per day for DVT.

The numbness in her right hand is unchanged.

General Review of Systems: Reviewed. No changes

Past Medical History: Reviewed. New history of DVT.

Social History: Reviewed. No Changes.

Family History: Reviewed. No Changes

Objective		
Vital Signs		
BP	106/66	
Pulse	72	
Temp	98.1	
Weight	150 lbs	
General Appearance Well-nourished		
Carotids	No bruits heard	
Heart	No murmurs	
Peripheral pulses	Normal	
Mental Status	Normal	
Cranial Nerves	Normal	
Gait and Station	Normal	
Tandem Gait	Normal	
Motor	Right	Left
Strength Normal	Normal	
Muscle Tone Normal	Normal	
Sensory	Right	Left
Pinprick Decreased over thumb, 2 nd finger, 3 rd finger and half of 4 th finger	Normal	
Vibration	Normal	Normal
JPS	Normal	Normal
Reflexes		

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Biceps 3+	2+	
Triceps 3+	2+	
Knee 3+	2+	
Ankle 3+	2+	
Babinski Sign Present	Absent	
Finger Jerks	Absent	Absent
Jaw Jerk	Absent	Absent
Tinel's sign	Present at wrist	Absent
Coordination		
Finger-to-Nose	Normal	Normal
RAM	Normal	Normal
Heel-along-shin	Normal	Normal

Medical Decision Making:

Assessment:

Epilepsy, Complex Partial—poorly uncontrolled

Carpal tunnel syndrome

DVT

Increased reflexes on right and right Babinski sign

Differential Diagnosis:

Hyper-reflexia on right in setting of seizures—r/o tumor r/o multiple sclerosis r/o infarct

Testing Reviewed:

None

Testing Ordered:

MRI of brain with contrast.

Other Therapies:

None

Patient Education:

I discussed diagnosis and plan with patient. She is to call me for any new seizures.

Because of the continued seizures we will add Depakote 250 mg po bid.

We will evaluate hyperreflexia with new brain MRI with contrast.

Medications:

Refill Keppra 750 mg po bid #60 11 refills

Refill Lamictal 150 mg po bid #60 11 refills

Continue Warfarin 5 mg per day

Start Depakote 250 mg per day

Return Visit:

1 months--sooner if problems occur

She should call for results of MRI after it is completed. Patient instructed.

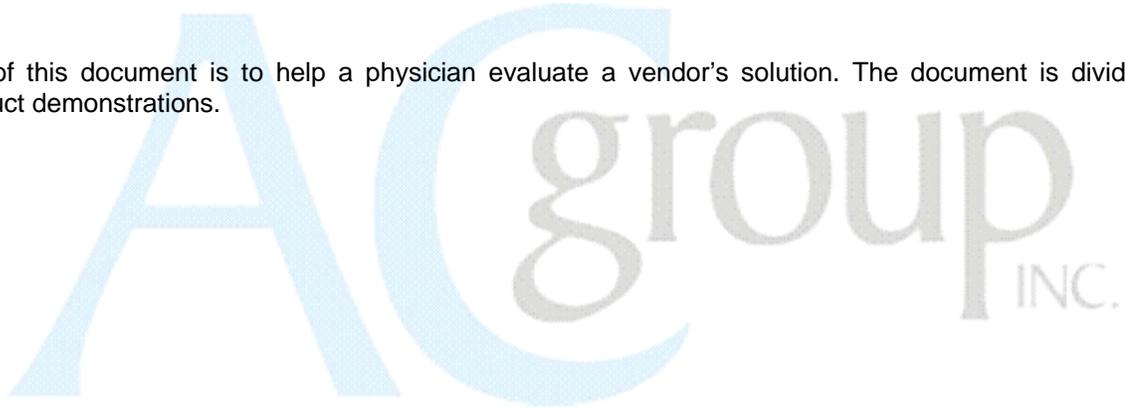
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Practice or Community Description:

Vendor Presentation: The vendor will have around 2 hours to present their company and their product. Additionally, I have attached a document that outlines the normal demonstration approach and what to cover during the demo. Please plan on presenting the materials requested. Plan on spending 5 - 10 minutes for company overview, 5 minutes discussion on similar sized clients, 15 minutes for questions and answers and the rest of the time for actual product demonstration. Please try to cover the issues outlined in this document.

Be prepared to show multi ways of data entry including Voice dictation directly into the application via a voice recognition application like Dragon Medical, handwriting recognition, as well as traditional "point and click" and typing. Also please bring handouts of the actual printouts or a printer so that we can see the output.

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For on-Site Demonstration

B. Company Overview

Questions	Response	Response
Company Name and Web Site		
Contact Name and Phone Number		
Total FTE Employees and number of employees dedicated to client support		
Explain how your product handles disaster recovery/data protection required by HIPAA regulation 164.308 effective April 2005?"		
Explain how you handle data backup of data.		
Assuming a fire in the computer room and the entire server and hard drives are lost, explain how all of the data entered throughout the day can be recovered since the last back up. Basically, is there any risk of losing any data.		
If any of your products are hosted via a web/internet connection, please explain how you insure a 100% uptime given the potential problems with servers, data lines, and communications.		
Explain how physicians can access the application from their home, the hospital, and from an internet café overseas. What security and privacy concerns might there be with such access?		
Since hospitals and other internet capable sites do NOT allow software to be loaded on a local PC, explain how a physician would access data w/o loading any local software on a local desktop PC.		
Explain your wireless mobile capability.		
Explain security, audit trails and privacy capabilities.		

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For on-Site Demonstration

B. Company Overview

Questions	Response	Response
PM Product Name and Version		
Annual Revenues the last 2 years		
Total PM Clients and locations		
Total PM Clients and locations that match our size and specialty		
Recommended Operating System and Database		
Is there a Single database (all components share a single, unified database)? Explain.		
Integrated - do all components (PM, EMR, etc.) work together transparently, that is, the user does not have to do anything and does not see anything related to the internal workings?		
Is your PM otherwise interfaced with your EMR application? Explain how and what the user sees or has to do to make them work together, that is, "help" the information move from one component to another.		

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The Digital Medical Office of the Future
Documentation Challenge - Section C
Scheduling, PMS, DIM, and Admin. Documentation

Scheduling Task	Comments
A current returning patient calls in for a new appointment	
Show how you search for a patient base on name and how do you determine if you have the right information	
Show how the scheduling staff is able to view a prior-patient's current balance and date of last payment before scheduling their next office visit.	
Show how HIPAA alerts are represented. Besides the patient, who else is cleared to speak with and who is restricted. Show the ways that they may be contacted. For example, the husband is not allowed to view the wife's clinical or financial record.	
Schedule the patient for a new workman's comp visit with a new workman's comp carrier and for a re-check for the sprain ankle from a prior non-workman's comp injury that is covered under the patient's primary insurance plan. Basically two reasons for appointment during the same visit. Also explain how insurance is attached to each Appointment based on the injury or responsible party (Workman's Comp)	
Show mentions for finding an open appointment slot. Search by day by physician, and 3 rd Thursday in the afternoon.	
Schedule a second patient – this time a new patient.	
New Patient calls to schedule a visit. Search for the patient and describe how the scheduling clerk is confident that the patient has NOT been to this practice before.	
Set up temp account and schedule the patient for a routine new patient visit.	
The clerk will then ask the patient if they would like to fill out their registration and clinical profiles on line or if they would like the information sent to them. If they want to complete the information on line, how does the clerk indicate that in the system and how is the patient informed of the required information.	
Show how your PMS/EHR allows a patient to complete required forms on-line before they show up for their first visit. (History info and if it can be added to the nurses intake)	
Show options for setting up the schedule template	
Demonstrate how to see 3 to 5 physician schedules at one time, on one screen – per day, per week. Show individual schedules for week, month. Show how to find openings in a group of physicians.	

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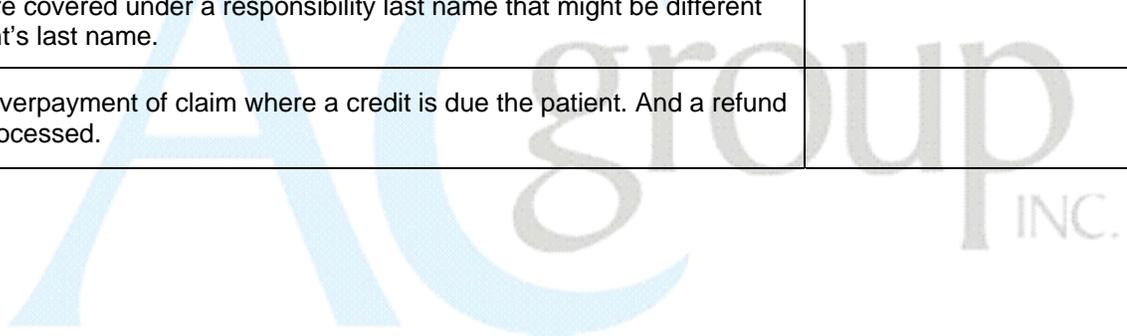
Scheduling Task	Comments
Show how to interface outlook and the patient scheduler. We have many meetings, show them combined with the patient/doctor schedule. Coordination with PDAs? Palm or Pocket PC format?	
Demonstrate how patients can give feedback/ fill out survey from waiting room kiosk or from home.	
Phone Messages Task	Comments
Demonstrate the systems ability to record phone messages and the route the phone messages to a nurse and to a physician. Also demonstrate the recording of a billing question and then forward the question to one of the billers.	
Demonstrate the ability to view health maintenance alerts when scheduling patients, reviewing patient information, and during patient phone calls. We would like to notify patients of overdue health maintenance issues at every opportunity.	
Patient Check-in	Comments
The patient arrives at the office for care and is greeted by the receptionist.	
Check the patient in, scan insurance card and driver's license. Demonstrate how insurance cards and registration information is scanned in and filed in a separate patient chart folder.	
Review registration information to include guarantor, Next Of Kin & Insurance screens, phone numbers including cell phone, email address, occupation.	
Demonstrate how the front desk person knows what the co-pay should be for this visit and any additional payments that are due today from prior visits.	
The patient brings in 5 pages of paper records. Demonstrate how the receptionist can scan in a patient's paper record and index the 5 pages to specific categories (Physician notes, lab results, Medical History form, paper prescription log)	
Demonstrate how the front desk checks patient's insurance eligibility at the time of check in or in a batch mode the night before.	
Demonstrate how the front desk staff can notify the nurses that a patient is ready to be seen.	
Assume that we are still using superbills since we have not implemented an EHR yet, what would the superbill look like and how does the form display which type of "case/reason" the patient is being seen for?	

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Documentation Challenge - Section C
Scheduling, PMS, DIM, and Admin. Documentation

Forms	Comments
Demonstrate electronic forms capabilities. We have selected forms that we would like to have automated. How ease is it to create our own electronic forms and templates?	
Demonstrate automatic and manually triggered workflow. For example, the patient is due for a selected test because of age. How doe the front desk and/or scheduler know to discuss the test with the patient.	
Demonstrate adding a new dependent with a different last name than the Guarantor. The dependent's insurance charges are covered under the step parent and the patient portion is covered by a different guarantor.	
Charge Capture and Coding - Assume now that the patient has been seen by the nurse and the physician and that we are still using superbills until the EHR is implemented.	
Demonstrate how charges and "correct" coding are entered? Enter a minimum of 3 charges with modifiers for visit (example -25 or -59) and modifiers for technical component of a test with and without the professional component. Explain your rules engine.	
Explain any human intervention in the coding process.	
Demonstrate how a co-pay it attached to a charge. Demonstrate effective and efficient way to collect that payment before the visit. Demonstrate how to avoid refund to the patient.	
Show us how we can differentiate between a co-pay and an on account payment if they are both made at the same time and how are corrections made.	
If changes are made in regards to coding a visit how is the provider notified that either the change was made or that he/she needs to make that change?	
Explain the process for submitting electronic claims to various 3 rd party payers.	
Show how to enter hospital diagnoses and charges.	
Demonstrate global billing for a procedure that includes multi follow-up visits.	
Demonstrate how staff confirm that WC charges are NOT assigned to the patient's primary insurance plan.	

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Documentation Challenge - Section C
Scheduling, PMS, DIM, and Admin. Documentation

Payment Posting	
Demonstrate simple payment posting of 3 rd party payments. Assume a health plan sends in a payment for multi patients. How do we record multi payments from one check, and how can we store the paper EOB for reference at a later time.	
Demonstrate payment posting where the 3 rd party denied one of the charges and paid a lower amount for another charge. Explain your rules engine for denied claims and lower payment posting.	
Demonstrate electronic remits and how to void or make corrections to them.	
Demonstrate posting of a patient payment that is mailed in.	
Demonstrate how the staff would search for a patient and post a check when the name on the check does not match any of your patents. Basically a step parent sends in a check for a child with a different last name. Can you search for all patients that are covered under a responsibility last name that might be different from the patient's last name.	
Demonstrate overpayment of claim where a credit is due the patient. And a refund needs to be processed.	



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Documentation Challenge - Section C
Scheduling, PMS, DIM, and Admin. Documentation

Tracking of Accts Receivable and unpaid claims	
Demonstrate the Tracking of unpaid claims.	
Demonstrate Reporting methodologies. Base report and customized reports. Can we run a report and then drill down into the details without leaving the report?	
Transfer to an outside billing house / Collection agency. Are there charges from you? Any other source of charges to us for sending electronic claims?	
Show how "NO SHOWS" and cancellations are documented and reportable.	
Demonstrate how the business office could use the DIM application for scanning and storing of paper records.	
Demonstrate how to customize a report. You will guide one of our administrators to customize a report during the demo	
Have copies of all standard (free) reports that come with your PM system.	
Print or display a bill for a patient.	
Show how to pull up a bill sent to patient when they call in with questions. Can we view the actual document that the patient is viewing? Can we view multi prior patient statements?	
Show how to enter hospital diagnoses and charges.	
Does reporting occur from the PM or EMR side or from both? Show us all of the diabetics with HgbA1C >8.0 and peripheral vascular disease.	
Show how to track AR for our entire company. Each division. Each physician and each extender.	
Show how to report number of times a charge is sent out; number of attempts/denials and why.	
Show how one deals with multiple physician ID numbers.	



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Section D - Nursing Questions

We now assume that the patient has been scheduled and checked-in, Now the patient is really to see the clinicians.	Comments
Demonstrate how the front desk staff notifies the nurses that a patient is ready to be seen.	
Demonstrate how a nurse can review their patient schedule for the day and print it out.	
Demonstrate how a nurse would handle incoming lab reports for review	
Demonstrate how a nurse would review and handle requests for re-fills. Any recommendations on how to automate this process?	
Demonstrate how a nurse would handle telephone calls and how workflow and task routing would be handled	
Demonstrate how a nurse could review the patient's prior visit information before seeing the patient.	
Demonstrate how a nurse can enter vital signs, chief complaints, current meds and allergies into the EMR/EHR. Demonstrate how patient can do this in the exam room, from a waiting room kiosk, and from home via internet.	
If the system provides electronic form capability, demonstrate how a nurse can enter vital signs and chief complaints into the system	
Demonstrate various methods that the nurse can interact with the patient's chart.	
Demonstrate the system's capability to maintain a patient's current problem list. (and how that list can be inserted into the current note and modified) . Demonstrate how to erase/correct any errors that have occurred in the problem list.	
Demonstrate your prescription writing capability.	
Demonstrate how an Rx can be filled by a nurse per a provider and how that Rx looks at the Pharmacy reflecting Filled by nurse ____ per Dr ____	
Demonstrate How a provider can fill narcotic that require a unique signature for each Rx and how that can be accomplished / Mandated it the system.	
Explain if your product interfaces with SureScripts, Express Scripts and RxHub. Which fax servers have you successfully and seamlessly interfaced with in the past 6 months	
Demonstrate how to order a lab. Show us a lab req. printed out and Demonstrate when the billing is sent out. Show us this process in a paperless system. We will need to both.	
Demonstrate how a physician would view records from their home and the hospital. Demonstrate how a non-employed physician could have view-only privileges (ie, our local ER)	



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Section D - Nursing Questions

Demonstrate how a provider can check out a chart into their local machine and go to a location where they can not access our network and chart on Pts then sync up when back in the building.	
<p>Demonstrate Non-provider data entry.</p> <p>Note: Many template driven database entry systems rely on nurse or clinical practice assistant to enter chief complaint (CC), brief history of present illness (HPI), and review of systems (ROS) as a way to lessen the time burden on the clinical provider. These entries by another provider are then already entered into the provider's note before they even enter the room. One innovative system, that we expect other EMR vendors to adopt, is to offer full EMR function, allowing the patient to enter this (CC, HPI, ROS, etc.) information at a computer kiosk while in the waiting room. Demonstrate how to limit a laundry list of complaints.</p>	
Demonstrate the system's capability to maintain a patient's current problem list.	
<p>Demonstrate multiple options for documentation of the clinical encounter. Include:</p> <ul style="list-style-type: none">○ Text typing or dictation○ Retrieving prior visits (selected by provider, department, diagnosis, chronologically most recent) as the foundation for the new visit○ Disease or symptom specific templates containing standardized text with "fill in the blanks," as well as "auto fill in the blanks" <p>Insertion of selected text blocks, anatomic diagrams, lists (problem, medication, allergies) results (lab flowcharts or graphs, x-ray, EKG tracings) into the encounter note formats above</p>	
<p>Demonstrate Viewing of progress notes and the clinical encounter as they are being built.</p> <p>Note: Some systems either offered split screen view or easily moved back and forth from template screens to clinical note. A few products kept you buried in multiple templates and pick lists with several steps involved to view the note this data entry was creating.</p>	
<p>Demonstrate Documenting process for:</p> <ul style="list-style-type: none">1) Provider comes out of the room and tells the nurse to give the Pt an:<ul style="list-style-type: none">A) IM InjectionB) IV InfusionC) EKGD) PFTs or Peak Flows <p>Pediatric Immunization with a print out of the Immunization record for the Pt. – Is there a pop-up system for recommended immunizations? Can it be turned off?</p>	



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Demonstrate how the Nurse notifies the physician that a patient is ready to be seen.	
Demonstrate how a Physician can review their patient schedule for the day.	
Demonstrate how a Physician would handle incoming lab reports for review. Demonstrate the system's ability to view lab results from outside companies. Do you provide HL7 interfaces? How much do you charge for these interfaces?	
Demonstrate how a Physician would review and handle requests for re-fills. Do we get report as to if patient picked up script? Show us.	
Demonstrate how a Physician would handle telephone calls and how workflow and task routing would be handled	
Demonstrate how a Physician could review the patient's prior visit information before seeing the patient.	
Demonstrate email system: demonstrate how to comment, sign, make orders from the same screen. <input type="radio"/> Detailed Description of Capabilities <input type="radio"/> Demonstrate Lab/X-ray result delivery to MD <input type="radio"/> Demonstrate Lab/X-ray response by MD (order) <input type="radio"/> Demonstrate availability of clinical data from email screen <input type="radio"/> Demonstrate follow up on emailed orders	
Demonstrate how the nurse entered vital signs, chief complaints, current meds and allergies into the EMR/EHR.	
Demonstrate various methods that the physician's nurse can interact with the patient's chart.	
Demonstrate the system's capability to maintain a patient's current problem list. Show how a physician can confirm or correct the problem list? (and how that list can be inserted into the current note and modified)	
Show your current summary sheet and explain how you are complying with the CCR acceleration coalition (CCRAC) recommendations for a uniformed snapshot view from all vendors.	
Demonstrate how fast an entire visit could be entered by the physician. Include the creation of the note, ordering labs, prescribing 2 medications, recording the most appropriate E & M code, creating and printing a note, and then sending a letter to a referring physician. Speed counts here. BY VARIOUS SPECILTIES	
Demonstrate various methods that the physician can use to interact with the patient's chart. Starts by having the physician review their Summary Worksheet. Show how the physician reviews their daily schedule, important results, signs a few documents and handles 1 refill request.	
Demonstrate your prescription writing capability.	
Demonstrate how an Rx can be filled by a nurse per a provider and how that Rx looks at the Pharmacy reflecting Filled by nurse ____ per Dr _____. Show how it is documented. How exactly is fraud prevented?	

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Task or Question	Comments
Demonstrate How a provider can fill narcotic that require a unique signature for each Rx and how that can be accomplished / Mandated it the system.	
Explain if your product interfaces with SureScripts, Express Scripts and RxHub	
Demonstrate narrative creation capability using structured database entry with practice specific templates transformed into narrative text by automated addition of linking phrases and formatting. The result combines the best of a searchable database with clinical encounters that read like the physician dictated them.	
<p>Demonstrate Viewing of progress notes and the clinical encounter as they are being built.</p> <p>Note: Some systems either offered split screen view or easily moved back and forth from template screens to clinical note. A few products kept you buried in multiple templates and pick lists with several steps involved to view the note this data entry was creating.</p>	
Demonstrate your clinical rules engines. Explain sources of your clinical decision support and knowledge base systems. Show support trees, guidelines, NCQA qualifications, etc.	
Demonstrate your E & M "correct" coding functionality. Explain how appropriate E & M codes are generated and how the product helps the physician code correctly. Show how you use SNOMED, etc. Show how to mark certain diagnostic codes as "high risk".	
Demonstrate specific rules and alerts.	
Demonstrate how OB/GYNs can maintain ACOG information.	
Demonstrate Pediatrics including growth charts and dosing requirements based on age and weight of pediatric patients.	
Demonstrate workflow between physician and the nurse.	
Demonstrate how the nurse and the Provider can document on a visit (same patient) at the same time.	
Demonstrate how a physician would view records from their home and the hospital. Is this via internet, VPN, other?	

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Task or Question	Comments
Demonstrate Preventive Health record capabilities.	
Demonstrate the system's capability of identifying patients that need to come back for an overdue procedure or test. Explain system's auto-workflow, for identifying and contacting the patient. Auto-call, auto-email reminders to patients about visit. Can we modify this to my voice? Example – "Hi, this is Dr Guss. I'm calling you to remind you that you have a visit at (computerized voice with time/date). If you are not going to be able to make it please call us ASAP so we can open up that time slot for another patient."	
Demonstrate the system's capability of recording "when" and "where" a prescribed medication is picked up by the patient. (23% of all medications are never picked up by the patient)	
Demonstrate how a patient would interact with their Personal Health Record (PHR).	
Demonstrate patient educational workflow. Explain source and updating capabilities for patient education materials	
Demonstrate how to make/prepare for group visits.	
Demonstrate as "discharge instruction" system for our Urgent Care.	
Explain an implementation timeline for our group, assuming that we enter into contract with your company.	
Develop a potential workflow for a typical family medicine or internal medicine clinic with our necessary interfaces and adjuncts.	
Show us your typical backup plans and plans when there is "downtime".	
Explain how we add other physicians or groups to our system. Describe how we could enterprise this software system to other outlying groups.	
Give us 5 sites, similar in scope and size that have your most current version (the one you're showing us) fully up and running. List also, the beta test sites with their contact info.	

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B. Best Features:

In addition, the following section highlights some of the best features discussed by functional area that the reviewers observed in the “drive through” of the top 6 vendors by self reported functionality. The description of these features purposefully does not specifically refer to the company or companies that they are associated with. We chose this method first of all because this will rapidly change as many of these innovate features will be adopted by the companies who currently do not have them. Secondly, in addition to providing information that would be useful in product and vendor selection we also sought to use this exercise as a tool to provide you with longer lasting information about the desirable features and functions to look for in an EMR product.

1. DOCUMENTATION

- **Multiple options for documentation** of the clinical encounter. These included:
 - Free text typing or dictation
 - Retrieving prior visits (selected by provider, department, diagnosis, chronologically most recent) as the foundation for the new visit
 - Disease or symptom specific templates containing standardized text with “fill in the blanks”
 - Insertion of selected text blocks, anatomic diagrams, lists (problem, medication, allergies) results (lab flowcharts or graphs, x-ray, EKG tracings) into the encounter note formats above
- **Narrative creation**
 - Structured database entry using templates transformed into narrative text by automated addition of linking phrases and formatting. The result combines the best of a searchable database with clinical encounters that read like the physician dictated them.
- **Non-provider data entry**
 - Many template driven database entry systems rely on nurse or clinical practice assistant to enter chief complaint (CC), brief history of present illness (HPI), and review of systems (ROS) as a way to less the time burden on the clinical provider. These entries by another provider are then already entered into the provider's note before they even enter the room. One innovative system, that we expect other EMR vendors to adopt, but was not tested as it did not offer full EMR function, allowed the patient to enter this (CC, HPI, ROS, etc.) information at a computer kiosk while in the waiting room.
- **View progress**
 - Vital to view the clinical encounter as it is being built. Better systems in this regard either offered split screen view or easily moved back and forth from template screens to clinical note. A few products kept you buried in multiple templates and pick lists with several steps involved to view the note this data entry was creating.

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2. ORDER ENTRY

- **Automated pick list content and sequence**
 - One of the most innovative features was a system that automatically re-arranged pick lists in the sequence of the most frequently ordered labs, x-rays, prescriptions at the top.
- **Prescription (Rx) writing**
 - Initial Rx contains a default dose, frequency, and SIG instructions, which can easily be overwritten if provider wishes to change.
 - Multiple refills can be ordered via click and drag or shift key hold selection rather than painstakingly requiring entry of each individual Rx refill.
 - Formulary information including a specific patient's insurer's preferred drug, required co-payment, and any requirements for pre-authorization
 - Comprehensive decision support for drug-drug interaction alerts with options to suppress certain alerts either by department or practice level (i.e. methotrexate – nsaid, methotrexate – sulfonamides)
- 1. **Alert system**
 - 2. System for alerting clinician to outstanding or overdue labs, x-ray, referrals, etc.

3. MESSAGING

- **Interoffice**
 - Messaging within the office or clinic allows for writing a message along with forwarding any clinical encounters, test results, block text from internal (EMR) or external (internet) decision support and assigning the message different levels of priority
- **Confidential**
 - Feature to create confidential equivalent of a "sticky pad" reminder and attach it to certain sections of the chart for viewing, but not have it print or entered into the medical record and easily deleted at any time.
- **Telephone**
 - Telephone encounter itself contains direct links to pharmacy ordering, results viewing, allergies, without time consuming exiting or multiple steps to access these commonly used applications.
 - Different levels of priority status can be assigned to telephone messages
 - Method of viewing at a glance whether telephone message has been viewed and acted upon by non-physician providers

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4. RESULTS VIEWING

❖ **General**

1. Easy to view and select all lab, x-ray, in a single location

❖ **Lab**

1. Selecting a specific lab automatically flows the last few values for comparison
2. All flowcharts can be displayed graphically
3. Ability to flow or graph more than one test simultaneously to track associations (i.e. LFTs and cholesterol, hematocrit and esr or iron binding profile)
4. Lab value can easily be entered into existing decision support formulas (i.e. creatinine clearance, 24 hr protein from prot/creatinine ratio)

5. CHARGE CAPTURE AND LEVEL OF SERVICE CODING

❖ **Correct Coding**

- ❖ Data entry for clinical encounter documentation leads to suggested level of service based on automated counting of data elements
- ❖ Clinician can view elements counted and see potential elements missing to meet next level of service
- ❖ System compares diagnostic codes and alerts clinician if order entry for testing or procedures inappropriate for that diagnostic code and therefore likely to be disallowed by either government or major commercial insurance carriers

❖ **Automated billing**

- The systems can document billing and coding requirements automatically based on the actual work a physician records in the patient chart.
- The systems can also automatically document the appropriate E & M coding based on specific insurance requirements.
- The system can auto post the appropriate information to numerous Practice Management Systems.

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5. ORGANIZATION AND GRAPHICS

- **Home base**

1. The best systems offered a comprehensive provider (rather than overall clinic) oriented home base analogous to a driver's dashboard or airline pilot's instrument panel. This is where the clinician returns to see the work to be done and the status of his current clinic schedule. This page contains incoming telephone and other messages, results, charts for review, daily schedule with location and status of patients and documentation. We found there is a fine art to organizing this with enough information to provide an overview, with links to easily review prior results, to enter new orders, to flag priority items, but not make this site so busy that it is overwhelming.

- **Navigation**

- The better systems offered multiple ways of moving around a single screen, between screens, or even between applications. The most advanced systems anticipated physician workflow and within the screen where work needed to be accomplished included the data or button bar links to access the most frequently used functions.

- **Patient interfaces**

- The future is likely to bring greater direct patient involvement in their care. EMRs that offer the option of internet-based access to patient self-scheduling and those that allow the patient to view parts of their record in a secure site will be keeping pace with this trend.

- **Touch screen**

- Touch screen technology will take on increasing importance as the notepad and other larger portable devices diffuse through the marketplace. These features will expand the functions that are practical to perform on "portable devices."

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Spending on technology by physicians has tripled since the 1990's and is expected to triple again in the next six years.⁽¹⁾ The majority of this increase will incur in the upper three levels of the IT maturity levels – basically the levels that require Physician interaction. It is anticipated that the average physician will be spending up to \$8,000 for an EMR and an additional \$3,000 for other related technology applications. Additional hardware, networks, and mobile devices, could raise the level of spending for the average physician \$15,000 per year on technology. Although some of these additional costs may be offset by reductions in transcription, medical record storage, improved coding and charge capture, this still represents a significant additional initial and recurrent cost, particularly for small office practices.

When choosing a system, one should focus on the system itself, its features, feel, and perhaps most importantly, the track record of the software vendor. When comparing prices between vendors, one must make sure that each vendor is offering comparable features and options.

Probably the single largest cost is the investment in the system hardware. Most systems require the same type of workstations but differ in the server that they require. Does the system force both small and large facilities to run the same server and database? This is important because not all physician offices require the same data storage capabilities. The higher-end databases that many EMR systems come with are excellent for physician offices that have the system administration resources to operate them, but they are probably not appropriate for smaller facilities.

EMR pricing models, like everything else, varies based on the services that are provided. In most cases, a physician can contract for a flat monthly fee of between \$400 and \$1,000 per month for the software application. However, the price varies for installation, training, and initial configuration. Some vendors require “consultative” fees upfront, instead of building into the monthly contract. Of course you still have all of the hardware and networking requirements. These are traditionally included in the monthly software costs, but can be added as a monthly lease cost. In all cases, physicians must look at a 3-year total-cost-of-ownership model when considering either a purchase or an ASP model. During our study we compared pricing for a 10 and a 5 doctor practices.

1 - AC Group, Inc. study of technology spending trends for small to mid-size physician practices

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How much does an EMR system cost? There are a broad range of costs associated with the purchase and implementation of a system. These include:

- Software licenses, which are typically sold on a per-workstation basis
- Hardware, consisting of both individual personal computers for office and exam rooms as well as central database servers, network hardware, and modems
- Training and implementation, which involves pre-installation planning as well as on-site training of individual users
- Software support, represented as an annual contract typically sold as a percentage of the total sale, providing both help desk functions (technical support) and software updates
- Hardware and network support, which is primarily on-site or telephone support for hardware-specific issues and problems
- Typical prices range from \$15,000 to \$50,000 per physician, including all of the components noted above.
- Software costs alone per physician vary by company and are not necessary related top functionality.

Costing Model Assumptions:

- A few vendor's offer their product as an ASP. Thus, their application pricing is lower than all turnkey systems. However, to off set the initial costs, most EMR vendors offer a lease option that reduces the first year costs by > 60%.
- A number of the comparative vendors also provide fully PDA software for charge capture, prescription writing, etc. For the purpose of the pricing comparison, we have not included any PDA devices.
- Hardware was configured the same for each product offering. Some vendors will require a smaller and less expensive server, but pricing for workstations and printers were assumed to be the same.
- Laboratory Interfaces and Practice Management Interfaces were added to all pricing comparisons.
- The committee received detailed pricing for six of the top EMR application vendors.

C. Cost Model: (see next pages)

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Cost Area	Company 1	Company 2	Company 3	Company 4	Company 5
Providers	40	40	40	40	40
PMS		\$ 7,500.00			\$ 3,000.00
EMR		\$ 7,500.00			\$ 10,000.00
DIM/other software		\$ 2,000.00			
Combined PMS/EMR	\$ 10,000.00		\$ 10,800.00	ASP Offering	\$ 13,000.00
Enterprise costs		\$ 20,000.00			
First Provider	\$ 10,000.00	\$ 37,000.00	\$ 10,800.00	\$ -	\$ 13,000.00
Additional providers	\$ 7,500.00	\$ 17,000.00	\$ 10,800.00	\$ -	\$ 13,000.00
Software Costs - PMS/DIM & EMR	\$ 302,500.00	\$ 700,000.00	\$ 432,000.00	\$ -	\$ 520,000.00
Average cost per Provider	\$ 7,562.50	\$ 17,500.00	\$ 10,800.00	\$ -	\$ 13,000.00
Annual Support Fee					
Software Upgrades and support	\$ 54,450.00	\$ 126,000.00	\$ 90,720.00	\$ 393,600.00	\$ 98,800.00
Maintenance Fee: product upgrades and content usage for drug database and Drug Interaction checks and continued interface with medical devices & Lab interfaces is required.	\$ 1,960.00	\$ 15,800.00	\$ 1,960.00	\$ 1,960.00	\$ 1,960.00
Telephone Support	\$ 24,000.00				
Claims Interface (Direct)	\$ 28,320.00	\$ 28,320.00	\$ 28,320.00	\$ 28,320.00	\$ 28,320.00
Total Annual Support	\$ 108,730.00	\$ 170,120.00	\$ 121,000.00	\$ 423,880.00	\$ 129,080.00
Interfaces					
Lab Interface	\$ -	\$ 5,000.00	\$ 1,500.00	\$ -	\$ 5,000.00
Hospital	\$ 5,000.00	\$ 25,000.00	\$ 5,000.00	\$ 5,000.00	\$ 5,000.00
Direct Claims Set up					
Total Interface Costs (estimated)	\$ 5,000.00	\$ 30,000.00	\$ 6,500.00	\$ 5,000.00	\$ 10,000.00

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Cost Area	Company 1	Company 2	Company 3	Company 4	Company 5
Installation					
Days on Site	\$ 8.00	\$ 10.00	\$ 8.00	\$ 8.00	\$ 8.00
Cost per Day	\$ 750.00	\$ 1,900.00	\$ 1,550.00	\$ 1,500.00	\$ 1,600.00
Total Costs	\$ 6,000.00	\$ 19,000.00	\$ 12,400.00	\$ 12,000.00	\$ 12,800.00
Training					
Days on Site	\$ 50.00	\$ 60.00	\$ 50.00	\$ 50.00	\$ 50.00
Cost per Day	\$ 750.00	\$ 1,900.00	\$ 1,550.00	\$ 1,500.00	\$ 1,600.00
Total Costs	\$ 37,500.00	\$ 114,000.00	\$ 77,500.00	\$ 75,000.00	\$ 80,000.00
Total Installation and Training Costs	\$ 43,500.00	\$ 133,000.00	\$ 89,900.00	\$ 87,000.00	\$ 92,800.00
Travel Expense (estimated)	\$ 17,400.00	\$ 21,000.00	\$ 14,500.00	\$ 17,400.00	\$ 11,600.00
Shipping	\$ 50.00	\$ 50.00	\$ 50.00	\$ 50.00	\$ 50.00
First Year UP front costs					
Software	\$ 302,500.00	\$ 700,000.00	\$ 432,000.00	\$ -	\$ 520,000.00
Installation and Training	\$ 43,500.00	\$ 133,000.00	\$ 89,900.00	\$ 87,000.00	\$ 92,800.00
Interface Costs	\$ 5,000.00	\$ 30,000.00	\$ 6,500.00	\$ 5,000.00	\$ 10,000.00
Travel Costs (Vendor)	\$ 17,400.00	\$ 21,000.00	\$ 14,500.00	\$ 17,400.00	\$ 11,600.00
Shipping Costs	\$ 50.00	\$ 50.00	\$ 50.00	\$ 50.00	\$ 50.00
Data Migration	\$ 5,000.00	\$ 10,000.00	\$ 5,000.00	\$ 5,000.00	\$ 5,000.00
Server Hardware (estimated)	\$ 80,000.00	\$ 120,000.00	\$ 80,000.00	ASP	\$ 100,000.00
Discount					\$ -
Total First Year Upfront Costs	\$ 453,450.00	\$ 1,014,050.00	\$ 627,950.00	\$ 114,450.00	\$ 739,450.00

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Cost Area	Company 1	Company 2	Company 3	Company 4	Company 5
Annual Software Support and Maintenance	\$ 108,730	\$ 170,120	\$ 121,000	\$ 423,880	\$ 129,080
Annual hardware Support and Maintenance	\$ 12,000	\$ 18,000	\$ 12,000	\$ -	\$ 15,000
Total First Year Costs	\$ 574,180	\$ 1,202,170	\$ 760,950	\$ 538,330	\$ 883,530
Second Year Costs	\$ 120,730	\$ 188,120	\$ 133,000	\$ 423,880	\$ 144,080
Third - fifth year annual costs	\$ 120,730	\$ 188,120	\$ 133,000	\$ 423,880	\$ 144,080
Five year total costs	\$ 1,177,830	\$ 2,142,770	\$ 1,425,950	\$ 2,657,730	\$ 1,603,930
Cost per Provider per month over five years	\$ 490.76	\$ 892.82	\$ 594.15	\$ 1,107.39	\$ 668.30
Cost per Provider per Year					
Yr 1	\$ 1,196.21	\$ 2,504.52	\$ 1,585.31	\$ 1,121.52	\$ 1,840.69
Yr 2	\$ 251.52	\$ 391.92	\$ 277.08	\$ 883.08	\$ 300.17
Yr 3	\$ 251.52	\$ 391.92	\$ 277.08	\$ 883.08	\$ 300.17
Yr 4	\$ 251.52	\$ 391.92	\$ 277.08	\$ 883.08	\$ 300.17
Yr 5	\$ 251.52	\$ 391.92	\$ 277.08	\$ 883.08	\$ 300.17

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Financial Questions for Vendors

Here, in a nutshell, are some tips, tools, and tricks of the trade we've gathered from others and from our own reporting on how to judge a vendor's financial health and staying power. They may help you get beyond and behind an EMR vendor's financial statement before you place your practice in a long-term arrangement with that vendor.

- **Spotting fiscally prudent niche vendors.** Marketing is expensive. If you're evaluating niche EMR vendors, look for those with successful marketing deals. Small companies with niche products enhance their chances of survival if they don't compete with the big guys and have marketing deals to take advantage of bigger partners' distribution channels.
- **Stock analysts' views affect vendors' finances.** If a publicly held company has poor results and loses credibility with analysts, its stock may never recover. That's bad for customers, as stock prices are important to people who provide vendors with working capital. How do you get this information? It's far simpler than ever before. If you open a small stock account with one of the better on-line brokerages, some information is there free. Usually, you'll need a fairly big account to get free access to the very best analyst information.
- **Think both backward and forward about technology. History repeats itself, especially when it comes to technological gadgets.** If unique or novel software is combined with a unique or non-standard hardware product, then fast obsolescence and the need to plan for upgrades are virtual certainties. For example, the current efforts by vendors to offer computerized physician order entry on portable products like the Microsoft Tablet PC and PDAs come to mind. Quite possibly, small-unit hardware and software is the future of EMRs. Therefore, when considering vendors of these products, the key financial question is, "Will the vendor survive and offer upgrades when (not "if") the current product is obsolete?"
- **Watch your vendor's acquisitions.** A vendor can stumble by buying businesses outside of their core competency -- or even in it. WebMD bought over 10 companies in the late 1990s, and then struggled for years to merge their disparate software architectures into sets of software it had promised.
- **Profit is not a dirty word.** No, you don't want to be price-gouged, but a vendor must make a profit or disappear. Beware that some vendors' financials may be hiding low profits behind acquisitions of new companies. WebMD, when it went on its acquisition spree, was a leading example in health care IT. It was greatly helped by the late-1990s Wall Street attitude that profits mattered little in the short run, as long as sales were increasing. Wall Street raised WebMD's stature at a time when alarms should have been sounding.
- **Compare sales, releases, and implementations.** Software delays can start a vendor on an irreversible downward fiscal spiral. This is what happened to a number of HBOC products before McKesson took over. So, when you're acquiring a major system, we suggest that you demand from each finalist vendor, in confidence, for each product release, a table of:
 - sales by year
 - releases by year, and
 - Implementations by year.
- **The timing of revenue recognition is the most frequently fudged financial number in healthcare IT.** Have a financial person compare your candidate vendors' financials for their revenue-recognition practices. Especially, watch for actions in recent years to accelerate revenue recognition, or revenue recognition policies significantly more aggressive than those of other vendors. In:

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- Revenue recognition for software sales was more aggressive than for the EMR software business generally;
- Certain EMR vendors have changed their revenue recognition to even more aggressive practices in the past two years.
- Some vendors even attempted to change the way it charged for support, seeking to make clients start paying at contract signing rather than after an implementation and shakedown period, as is customary in the business. That change is doubly significant if one considers the fact that a significant number of EMR software products are still not ready after contracts were signed. In other words, the change could have conceivably forced buyers to pay support for years without a delivered, much less implemented, product to support.
- **"Hey, buddy, wanna side letter?"** Being offered a side letter or a deal with easy "outs" is the most glaring, lights-flashing, Klaxon-sounding alarm you could possibly get that the vendor with which you're thinking of a long-term relationship is trying to patch the hull of a leaky financial ship in mid-ocean. If you're offered an easy way out of a contract, ask yourself, "How much of the vendor's stated revenue is other contracts like this?"

But numerous physicians apparently mistakenly thinking that a side letter was a safety net, held their noses and signed them. Bad move. Almost universally, side letters are evidence that the software just signed for isn't ready and that the finances of the vendor are a sham. What good does it do you to have a side letter if the non-delivery of the software keeps you from moving forward with mission-critical information systems -- or if the vendor were to file for bankruptcy after taking your money? Obviously, none.

- **Is the vendor's market volatile or shifting?** No matter what kind of a year a vendor had the year before, the coming years could be different. Serious belt-tightening by Physicians on information systems purchases occurs every few years. It happened in 1991 and again, worse, in the period 1999-early 2002. These declines hit vendors and individual product lines unequally. When buying, you'll obviously need to make a judgment call about whether each candidate vendor is heavily dependent for its revenues on a product that is no longer in fashion or needed.
- **A vendor's performance for current clients is a key clue to its financial situation.** Support and implementation staffing are big cost centers. Be aware that some clients who are stuck with their eggs in one vendor's basket will not speak frankly about trouble because they understand that new sales are the vendor's only possible financial lifeline (and theirs). Some others complain more than may be warranted. Reality, on vendor support performance, tends to be an average, not a fact.
- **Troubling fiscal footnotes.** Even when the financial statement looks rosy, some details shout "trouble":
 - **High or rising receivables.** Receivables will rise with a spurt of recent sales, of course, but they may also signal withheld payments, which is probably a sign of troubled software. Also, a bulge in so-called "unbilled receivables" may signal slow installations, or, again, bugs in software.
 - **"Significant derogatory data" on a credit report.** In the view of Experian, which is in the business of examining whether companies and people are creditworthy (that is, whether a bank would find it a good risk as a business partner), pledging any of these as collateral for credit is significantly derogatory to creditworthiness: "accounts receivable, inventory, contracts, proceeds, hereafter acquired property, leases, or notes receivable." Patents, copyrights, and office equipment and furniture used to be on that list.

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- The significance of borrowing against these assets is that it may be a signal that much of the claimed revenues in a P&L are receivables -- which, of course, may not ever actually be received. Or, a new loan against assets may indicate that the business has suffered deterioration since its last financial statement.

- By the way: do you run a credit report on each candidate vendor for a major acquisition? Why not? It's a good, inexpensive way to double-check a lot of facts.



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Partial EMR Vendor List

Company Name	Product Name
7p PRM-on-Demand Suite™	7 Medical Systems™, LLC
ABELMed PM - EMR	ABELSoft Corporation ®
Opt!® Medical Professional	Accudata Systems
AcerMed EMR	AcerMed Inc.
AIMed EMR	Acrendo Software
ProgNote/MobileLink	ACS
WritePad™ EMR Systems	Addison Health Systems Inc.
OptimumSeries	ADL Data Systems, Inc.
MedicDocAssistant	Advanced Data Systems Corporation
AdvancedEMR	AdvancedMD
AdvantaChart™	AdvantaChart™ Inc.
Aimset™	Aimset Corporation™
Alert® Outpatient	Alert® Life Sciences Computing, Inc.
Allmeds EMR System	AllMeds Inc.
TouchWorks™	AllScripts Healthcare Solutions
HealthMatics®	AllScripts Healthcare Solutions
TexTalk Medical	Alma Information Systems
Universal e-Health MD® (UeHMD)	AlphaGlobal-IT Inc.
AltaPoint EMR	AltaPoint Data Systems LLC
Alteer Office®	Alteer Corporation
OncoEMR	Altos Solutions
Amazing Charts	Amazing Charts

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Company Name	Product Name
eMRimaging™	American Medical Records, LLC
Electronic Patient Charts	American Medical Software
PsychNotesEMR	American Psychiatric Management Services, LLC
AmkaiCharts	Amkai
CureAccess	AMZ Access Inc.
Anasazi Assessment	Anasazi Software
PECSYS®	Aristos Group Inc.
PsychConsult Provider	Askesis
MediPort™ EHR	AssistMed, Inc.
AS-OBGYN	AS Software inc.
athenahealth®	athenahealth®, Inc
OneLook™	Avid Anesthesiology Solutions
Axolotl EMR	Axolotl Corporation
Chiropractic Note System	Beyond Software
PrognoCIS	Bizmatic®
Wellness Connection EHR	BlueWare
ePaperless Practice	BMD Services, Inc.
ONCOCHART	Bogardus Medical Systems, Inc (BMSi)
Bond Clinician EHR	Bond Technologies
RxScribbler	Brunmed/Scriptnetics
InteliDOX	Businet

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Complete Medical Records	C&M Medical Services
Cabinet NG	Cabinet NG
CareData Solution™ & GlobalPatientRecord™	CareData™ Patient Tracking
Fusion	Carefx
E-Record	CarePaths, Inc.
Accelerator™ 3.0	Catalis, Inc.
PowerWorks®	Cerner Corporation
ChartCare EMR	CHARTCARE, Inc
ChartConnect EMR	ChartConnect
ChartLogic™	ChartLogic Inc.
ewebview™	ChartOne™, Inc.
Chartscape	Chartscape
ChartWare®	Chartware Inc.
ChiroTouch	Chirotouch
DC-PowerNotes	ClaKen Software, LLC
CMS Systems, EMR	Clearly Medical Solutions, Inc
PracticeEMR	Clinical Automated Office Solutions / CAOS
Pronto	Clinical Insight
Essentris™	CliniComp, Intl.
Accel™	CliniWorks™
CodoniXnotes	CodoniX, Inc

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ComChart EMR	ComChart ®
Companion EMR	Companion Technologies
MD Advantage	Compulink
Sevocity™	Conceptual MindWorks, Inc.
VisionEMR	Contec Vision Ltd.
CorEMR	CorEMR
Lynx CosmetiSoft	CosmetiSoft©
Medical Practice EMR 14	CPSI - Computer Programs and Systems, Inc.
Clinic Pro Software	Creative Concepts in Communications
Medformix®	Crowell Systems
Case Notes™	CSW North America
CureMD PRS®	CureMD PRS®
Endo Express™ / MediChart Express™	Cyber Records Inc.
ChartStar/Asystar	CYGLERA Health Systems
Physician Practice Documentation	Dairyland Healthcare Solutions
Clinical Practice Facilitator V5.5	DataBases For Doctors, Inc.
DataMed	DataMed Systems
Visionary	DataNet
PowerSoftMD	Data Tec, Inc.
ScriptSure	Daw Systems Inc.
The Chart!	DescriptMED, LLC
digiChart®	digiChart

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Company Name	Product Name
DOC™	Digital MD Systems®
Doc-Tor	Doc-Tor.com
Doc-U-Chart for the Tablet PC®	Doc-U-Chart
DocOncology	DocComply
DoctorsPartner	DoctorsPartner
DocuMed®	DocuMed Inc.
DocuRehab®	DocuRehab® Software, Inc.
DocuTAP	DocuTAP
QuicDoc®	DocuTrac, Inc.
DOX Podiatry	DOX Podiatry
EMR Solutions	DrFirst Inc.
DSN Soft - Dental Exec	DSN Soft
e-MDs Chart®	e-MDs
eCast	eCast Corporation
eClinicalWorks	eClinicalWorks
Sunrise Ambulatory Care™	Eclipsys
EDIM	EDIMS, LLC
EMIS Primary Care System (PCS) Enterprise edition	Egton Medical Information Systems Limited
CareRevolution	EHS
Practical Medical Record	Electronic Pediatrician LLC
Elogently Stated	Elogently Stated

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Company Name	Product Name
eMedChart Ob/GYN	eMedChart, LLC
Patient-Centric® EHR	eMedicalFiles®, Inc.
EMR2	E Medical Solutions, inc.
Assure ERH	Emergis, Inc.
EmergisoftED™	Emergisoft®
EMR4DOCTORS	EMR4DOCTORS
EMR MD Vendor	EMR MD Vendor
Doctors Choice EMR™ & Nurses Choice EMR™	EMRSystems
EMR Easy	EMR Technologies
eNATAL	eNATAL, LLC
TouchChart	Encite Inc.
PARIS/NXL (Patient Automated Records Information Systems)	Encore Associates, Inc.
EpicCare EMR	Epic Systems Corp.
ePowerDoc	ePowerDoc, Inc.
EMRitus	Ergo Partners
Evolution EMR	Ethidium™ Health Systems
Power Practice	Exan Mercedes Software Inc
EXmedic EMR™	EXmedic Software, LLC
RemedyEHR	Experior Healthcare Systems
E-Record EMR	Exscribe, Inc
Insight MD	Firstaid Software

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MaximEyes®	First Insight Corporation
FreeMED	FreeMED Software Foundation
Centricity	GE Medical Systems
ECISplus	GEMMS
GeniusDoc EHR	GeniusDoc
GlanceEMR	Glenwood Systems LLC
gloEMR	gloStream Inc.
gCare™	gMed
PrimeSuite® 2006	Greenway® Medical Technologies
gScribe	Gscribe, Inc.
Multi-Specialty EyeMD	Health Care Intranet Technology
Retina+	Health Care Intranet Technology
Clinical View	Healthcare Management Systems, Inc. (HMS™)
INTERACTANT™	Health Care Software, Inc. (HCS)
DoctorAssistant	HealthHighway™.com, Inc.
Health Probe Professional	Health Probe
MedPointe®, MedPort®, Practice Made Perfect™	Health Systems Technology, Inc (HST)
e-Chart Plus	Healthware Solutions, LLC
ZipChart	Helixys
MD-Journal	HemiData, Inc.
Dentrix Enterprise	Henry Schein™, Inc.

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MicroMD ® EMR	Henry Schein® Medical Systems, Inc.
eMedRec	Holt Systems, Inc.
MediTracks	i2i Systems, Inc.
IatroChart	Iatroware
ICANotes	ICANotes
SamNotes2000	ICS Software Ltd.
iKnowChart®	iknowmed
iMARS 2007	iMARS Software Systems
iMedica Patient Relationship Manager™ (PRM)	iMedica Corp.
iMed Software	iMed Software
PerfectMed™	Imogen Universal
eChart	IMPAC Medical Systems Inc.
MD-Reports	Infinite Software Solutions, Inc.
PRAXIS EMR V3.0	Infor*Med Inc.
CareVoyant	Infosys
InHealth InSystems	InHealth Record Systems
MD InSite	InSite Systems
MedDocs	Integrated Digital Systems
Physician Workstation	Integrated Healthware / Previously Wang Healthcare
OmniMD ™	Integrated Systems Management Inc.
IC-Chart ™	InteGreat Inc.

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STIX EMR	Integritas, Inc.
Smart Doctor	Intelligent Medical Systems
Intercare Clinical Explorer - ICE™	InterCare DX, Inc.
MobileMD™	IntraPrise Solutions, Inc.
IntelliDose	IntrinsiQ Research, Inc.
UroChart™ EMR	Intuitive Medical Software, LLC
Siemens Medical Solutions USA, Inc.	INVISION® Clinicals
OfficeEMR™	iSALUS healthcare™
Caretrak™	ISPRIT, LLC
OpenEMR	ITD Unlimited, LLC.
EncounterPRO v 5.0	JMJ Technologies
Medifile®	Jonoke Software Development Inc.
ePatientChart	jRW Inc.
KeyChart®	KeyMedical Software Inc.
Kietra XPR	Kietra Corporation
SoftDent	Kodak Dental
Mercure EHR	Lakes Health Systems
LeonardoMD	LeonardoMD
PodMed EMR	Leum Software Solutions, Inc.
Life Record™	Life Record Inc.
LifeWatch LIFET.I.M.E.	LifeWatch Corporation, Inc.
Login EMR	LoginClinic, Inc.

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Company Name	Product Name
Medical & Practice Management (MPM)	LSS Data Systems
MacPractice MD	MacPractice, Inc.
ManagementPlus	ManagementPlus
CattailsMD Version 5	Marshfield Clinic®
PracticePoint® Chart	McKesson
Horizon Ambulatory Care™	McKesson
MedAxxis EMR	McKesson/Per-Se Technologies
iClinic®@MDLand.com	MDLand.com
MD Logic	MD LOGIC, INC.
MDoffice	MDoffice Inc.
MDSync EMR	MDSyncEMR LLC
MDTablet™	MDTablet, LLC
Medtopia	MD Technologies Inc.
Medamation™ MD	Medamation, Inc.
medappz	medappz
MedAZ	MedAZ
Medcere Orthopaedic EMR	Medcere, LLC
Welford Chart Notes	Medcom Information Systems, Inc.
MedcomSoft Record™	MedcomSoft Inc.
All-In-One	Medent®
eSimplicity	Medepresence, Inc
ophthalmicsuite™ and oiPACS™	Medflow

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Emergency Department Management System - EDMS	MedHost
Medi-EMR	Medi-EMR, LLC
Medical Club	Medical Club Inc.
mMD.net	Medical Communication Systems
MedicalNotes.com	MedicalNotes.com
Medical Office Online	Medical Office Online Inc.
MRO	Medical Records Online
Harmony e/Notes EMR	Medical Technologies International
Medicat®	Medicat, LLC
Digital Clinic	Medico System Inc.
MedicWare EMR	MedicWare
Medinformatix	Medinformatix
WriteMD®	Medinformix®, LLC
MediNotes e	MediNotes Corporation
MediLinks®	MediServe Information Systems, Inc.
Intelligent Medical Software / IMS	Meditab
Physician Care Manager	Meditech
emr4MD	Mednet System
MedPlexus	MedPlexus
ChartMaxx® / eMaxx®	Medplus® Inc.
MedRule™	MedRule Business Solutions, Inc.

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Company Name	Product Name
OpenVista®	Medsphere Systems Corporation
MedStar	MedStar Systems, LLC
MedtuityEMR	Medtuity, Inc.
meridianEMR	meridianEMR
iMDsoft®	MetaVision Suite
PracticeStudio.net®	MicroFour Inc.
Webchart EMR and MIE™ Minimally Invasive™ EMR	MIE - Medical Informatics Engineering
Misys. EMR	Misys Healthcare Systems
Momentum Healthware	Momentum Healthware
CYRAMED™	Mountain Medical Technologies Inc.
Mountainside	Mountainside
OPUS III	MSS
d-Chart	NCG Medical
Avatar 2006	Netsmart Technogies
NexTech	NexTech
NextGen® EMR	NextGen Healthcare Information Systems Inc.
MyNightingale	Nightingale
Nopali™ & Nopali Lite™	Nopali inc.
NoteworthyEHR	Noteworthy Medical Systems, Inc
Nuesoft Xpress	Nuesoft
OB Secure	OB Everywhere, Inc.

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SYSTOC	Occupational Health Research
FlexMedical®	OCERIS Inc.
ExamWRITER	OfficeMate®
Cottage Med	Open Source - Cottage Med
Optimus™ EMR	Optimus EMR, Inc
Optio QuickRecord Suite	Optio Software
FertiSoft	Ordinateurs Laval
Exit-Writer	Parker Hill Associates Inc
PatientKeeper®	PatientKeeper, Inc.
PatientNOW	PatientNOW
Patterson EagleSoft	Patterson Dental Supply, Inc.
PBOmd	PBO Corporation
EyeDoc	Penn Medical Informatics Systems
Practice Charts	PGMS, Inc.
OB TraceVue	Philips
Phyz Manager™ & Phyz EMR™	PhyzBiz, Inc.
Picis	Picis, Inc.
Clinicio™	PluralSoft, Inc.
PM/2 Software	PM/2
PowerMed Practice Suite	PowerMed Corporation
eIVF	PracticeHwy.com
Practice Partner®	Practice Partner/McKesson Corporation

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Company Name	Product Name
QuickPractice™	PracticePRO Software Systems Inc.
Practice Solutions® EMR	Practice Solutions®- a CMA Company
Practice Today	Practice Today
PiVoTs	Practice Velocity
OPTIX	Prima Systems
Version Nine	PrimeCare Systems, Inc.
Patient Chart Manager	Prime Clinical Systems, Inc
Instant Medical History ™	Primetime Medical Software Inc.
StreamlineMD	ProPractica, Inc.
Prototypical EMR	Prototypical EMR
Provation MD	Provation Medical
Epitomax®	PsyTech Solutions, Inc
Pulse Patient Relationship Management (Pulse PRM)	Pulse Systems, Inc.
Purkinje Dossier Clinical Note Writer	Purkinje
ezSOAP	QualTimeMed Software
Quick Notes EMR	Quick Notes
MediTalk	Quincy Systems, LLC
Rapid EMR	Rapid EMR
RelWare®	Reliance Software Systems, Inc.
SmartEHR	RemedyMD
MedNotes EMR	ROA Software Labs

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Company Name	Product Name
Rosch EMR-Allergy & Rosch Immunotherapy	Rosch Visionary Systems
Clicks® - Medical Information System	Roshtov Software Ind.
Intergy® EHR	Sage Software
Helix	Sajix, Inc
Sapphire EMR	Sapphire Enterprises
Medscribber™	Scriptnetics, Inc.
SecureChart EMR	SecureChart
SequelMed®	Sequel Systems, Inc.
NationalEMR™	Sequence Managers Software, LLC
Sigmund	Sigmund Software
SynergyEMR	Sindhu Synergy Ltd.
SmartMedix	Smart Data Systems Inc.
Nauvalis HealthCare Solutions	Smart Document Solutions
SOAPware®	SOAPware, Inc.
Easy Chart™	Software Performance Specialists Inc.
Aquifer.EMR™	Solventus™
MedEvince	Sonix Healthcare Solutions, Inc.
SpringCharts™ EHR	Spring Medical Systems Inc.
SRS Chart Manager™	SRS Software, Inc.
SSIMED EMRge™	SSIMED, LLC
Q.D. ClinicalEMR	STAT! Systems

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Chartmaker ®	STI Computer Services Inc.
OrthoPad®	Stryker
SIS Solutions	Surgical Information Solutions
General Medical System/2	Symmetry Information Systems
Synamed	Synamed
Synapse EMR	Synapse Direct
Clinical Navigator	Systemedx, Inc.
T-System, Inc.	T-System, Inc.
AeroMD	TetriDyn Solutions
ChartEvolve	The CIMS Group
Navigator Web™ EDIS	The Poseidon Group, Inc.
TheraManager™	TheraManager™ LLC
ReDoc	The Rehab Documentation Company, Inc
TotalChart EMR	TotalChart, Inc.
Veerata EMR	TranzEMR
MedTemps	Trigram
Turbo-Doc EMR	Turbo-Doc Inc.
Team Chart Concept	Ulrich Medical Concepts
Unifi-Med	Unifi Technologies
UniCharts	UnisonCare Corporation
EndoSoft	Utech Products, Inc.
ChartKeeper ®	VantageMed Corp.

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ARIA™ Oncology Information System	Varian Medical Systems, Inc.
Vericle® EMR	Vericle, Inc.
VersaForm EMR Basic Edition	Versaform Systems Corp.
VersaSuite EHR	VersaSuite
VersaSuite 7.5	VersaSuite
smartEMR	Vipa Health
Virtual Medical Network	Virtual Medical Network, LLC
Visionary™ DREAM EHR 7.1	Visionary Medical Systems, Inc.
Office Practicum®	Visual Data LLC
VisualMED Clinical Information System	VisualMED Clinical Solutions Corp.
Vox2data / Pacific Voice for Medicine Second Generation	Vox2data
Waiting Room Solutions EMR	Waiting Room Solutions, LLLP
WEBeDoctor®	WEBeDoctor®
Wellogic Consult	Wellogic
Wellsoft EDIS	Wellsoft Corporation
Tablet MD™	WiFiMed, Inc.
MediExpress (C)	WIMcare
Windent	Windent
Wolf EMR	Wolf Medical Systems, Inc.
workflowEHR™	Workflow.com, LLC
Community EHR	Xeniamed

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xpressUC & xpressEDIS	XPress Technologies
zChart	zChart Electronic Medical Records

Conclusion:

Technology is only a tool and if used effectively can improve the flow of information and potentially improve the efficiency of the physician's practice. However in reality, if "change" is not embraced, the probability of success is very low. We learned in the 1980's that we needed to change the process of billing for services – or we would not be paid in a timely and effective manner. Therefore, the practice of medicine, from the business point of view, changed. Now with newer technologies, government regulations, and the right financial incentive, physicians will begin embracing new levels of technology that were not available just 5 years ago. But where does a physician in a small practice turn to learn about the 100's of technology choices? The physician can spend hours searching and evaluating all of the opportunities. Or maybe in the near future, physicians will be able to look towards leaders within

