



Case Study

MediNotes in Practice



Fast Track for Documentation Flow

by Stephen Coleman, MD

Coleman Pediatric Associates, P.A. opened in October, 2002 and has grown to just over 500 active patients, despite an unfavorable economy. We currently manage the office with a minimal staff of a receptionist, nurse, and practice manager. I plan to add a second pediatrician and to expand to 8 staff members over the next two years. I anticipate the average volume when fully scheduled to be around 24 patient visits per doctor each day.

Anticipating the growth of my practice, I selected MediNotes e, MediNotes Corporation's user friendly electronic health record, as a key element in our practice plan from the very beginning. Because we were starting a brand new practice, it made good sense to start with an EHR from day one rather than adjust to an EHR after the workflow had become established. We designed our practice workflow to match the system, which enabled us to maximize the benefits from the electronic system.

Increased Patient Volume

MediNotes e is user friendly and enables us to work efficiently without making doctor or staff members break a sweat. I expect to be able to handle up to 28 to 30 patients daily during busy cold and flu season and still have a life outside of the office. This system has made Coleman Pediatric Associates more efficient by allowing a capacity of six patients per hour to flow smoothly while maintaining timely clinical documentation. At normal flows of about 24 patients per day, documentation with the EHR can be done at the time of service. At "high flows" during our cold and flu season, I may have to do my documentation on a few patients over a small portion of my lunch hour. That contrasts very favorably to dealing with tall stacks of charts through lunch and after-hours as is often the case with completely "paper-based" notes.

Legibility with a Search and Discovery Tool

Legible documentation has been another benefit of using MediNotes e. The process of interpreting illegible notes takes valuable time away from patients. That is not the case here. With the system, I can also use the computer to sort and generate lists of patients. For example, I can find patients with ailments in common and locate medication lot numbers through the filtered medical history category. The system is my search and discovery tool. Because the patient information is categorized and organized in tabbed "folders", it is very easy and efficient to use in daily operation. I've been able to reduce my clinical documenting time by two or three minutes per patient, which means that I can spend more time to ensure that the parents of my patients fully understand the treatments that I've prescribed. More efficient patient flow through visits also helps to keep patient waiting times low.

Documentation Milestone

MediNotes e reduces our reliance on the physical chart. However, I can still easily gather and document the pertinent positives and pertinent negatives for multiple organ systems that are required for accurate CPT coding of visits. The MediNotes e medical library provides access to the 2003 ICD-9 and CPT codes available from the AMA. The Coding Wizard has E & M codes associated with the required documentation elements. Furthermore, MediNotes e allows more complete documentation through routine exam results being readily documented through templated notes. Most exams can be documented into complaint or diagnosis specific note templates that have a user specific, pre-populated default text. This EHR can provide immediate detailed notes for audits.

"Considering the level of benefit we have received in such a short time, I cannot understand why doctors would walk a mile for their medical records instead of clicking a mouse."

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MediNotes e version 5.0 is proud to be CCHIT certified for Ambulatory EHR 2006.



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The EHR also provides increased risk management rewards because MediNotes e assists with "documentation by exclusion". I add the information that differs from a normal exam and can do so very quickly with simple point-and-click selections from customizable dialog boxes and choice lists. The template prompts me to hit all the necessary history, exam, and plan elements for a particular visit, but I only take time to actively document the abnormal items. However all pertinent positives as well as the pertinent negatives are listed in the final clinical note. With anatomical graphic images that can be selected and included in the saved note, precise locations can be noted visually and progress can be monitored over time by including digital images from successive visits. In addition, the practice receives fewer insurance claim denials since our documentation is complete to support our visit coding for billing. Moreover, this is all accomplished without the financial investment or time-cost related to clinical dictation and transcription.

Information Relay Prevention

At Coleman Pediatric Associates we document telephone calls and call-backs without referring to a hard chart because we can instantly access the medical record on the nurse and doctor's computer. Consequently, follow-up calls are relatively easy. Charts are available on several patients at once without walking charts around the building. Also, outside documents can be scanned into a patient's electronic record. Coleman Pediatric Associates currently only uses a "hard chart" to keep hard copies of lab results or other documents where future primary source verification might be needed.

Curtailed Record Globe-trotting

The hard chart is minimal and simple and therefore easier to adequately safeguard against inappropriate or unauthorized access, enhancing HIPAA compliance. MediNotes e has password protection and includes access to functionality based on the level of the individual user's license. It enables the storage of medical information without floating charts around to various people and outside eyes. Circulation is minimal and no offsite transportation is ever necessary. In our office, the system is not yet in each exam room, but configured at each staff member's desk. The Digital Signature authenticates who saves patient notes and it has a time stamp. Therefore, we track who enters a medical record and alters information.

Economically, our network hardware, the billing software, and EHR had a nominal financial cost of approximately \$25,000 with about \$5,000 of that required for implementing MediNotes e. Monthly support and upgrades cost about \$100.00 a month to operate MediNotes e. This is an invaluable investment that furthers my practice goals. I can ensure my patients of a thorough examination, diagnosis, and therapy plan, and also of efficient, complete, and secure medical information management. In the future, I look forward to putting prescriptions on the system as well. Considering the level of benefit we have received in such a short time, I cannot understand why doctors would walk a mile for their medical records instead of clicking a mouse.

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