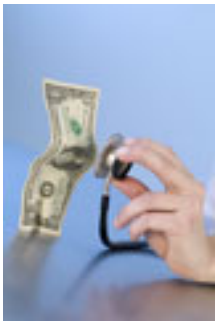
AC group INC.

Information Technology TRENDS and SOLUTIONS

Clinical and Operational Transformation

To insure an effective PMS and EHR implementation, healthcare organizations need a 3rd party organization to assist with implementation oversight and Clinical and Operational Transformation. For the past two years, we have been evaluating best practices in PMS and EHR implementations. However, instead of finding numerous best practices, we found that 73% of physicians are not using their EHR for 80% of their patients after one year. Therefore, we classify this as an EHR failure, since the practices have not fully automated clinical and operational processes after a year. We also determined that healthcare vendors cannot and will not guarantee a successful implementation. Therefore to insure success, healthcare organizations need 3rd party help with configuration, training and product optimization from a business process approach, not just the vendor's technical approach.



To assist our provider clients, we have developed a program to assist your organization to move towards a "Digital Medical Office of the Future". AC Group will provide your organization with implementation oversight and Clinical and Operational Transformation. Clinical and Operational Transformation is conducted onsite and remotely via email, web casts, and conference calls. The main purpose is to monitor the vendor's responses to your needs and to insure an effective implementation. AC Group will strive to eliminate the client/vendor miscommunications that occur in 85% of all EHR implementations. We will assist in the "Change Management" process that must occur to insure effective use of the new systems. Finally, we will also assist your organization with the process of Clinical and Operational Transformation in order to reduce risk, improve financial gains, and to reduce the "change pain" factor.

To insure an effective implementation, we have developed the following table that highlights the roles and responsible of the Vendor, AC Group, Inc., and the Practice Team.

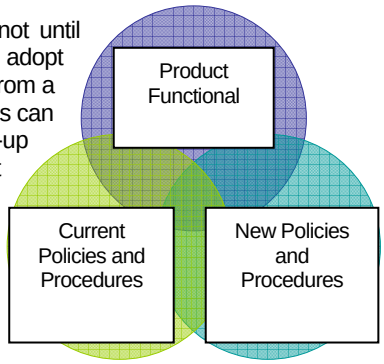
EHR Vendor	AC Group, Inc.	Practice
Deliver Technology Product	**Ensure Value Delivery & Facilitate Exchange**	**Adopt & Perform with New Solution**
Provide EHR Best Practices	Strategy – Goal Alignment	Provide Sponsorship
Tech System Assessment	Assess Readiness	Commit Resources
Build Technology Interface	Create Program Structure	Make Decisions
Present Standard Templates	Program Communications	Steering Committee
Train Super Users	Program Planning & Management	Practice Management Liaison
Train Users	Process Development	Clinical Liaison
Configure Software	Benefit Tracking	Administrative Workflow Team
Load Software	Change Management Activity	Clinical Staff Workflow Team
Test Support	Vendor Management	Provider Workflow Team
Respond to Change Requests	Roll Out Management	Billing Workflow Team
	Integrate Lessons	Technical Workflow Team

Implementation Oversight and Clinical and Operational Transformation Services

Proposal Content

Before beginning the adoption of new technologies, an organization should review and establish new operating polices and procedures designed to maximize the benefits of newer technology while reducing the negative affect of "Change". Each organization must consider "clinical and operational transformation". We will work with each of the assigned practices to maximize the use of the installed EHR while insuring the data collection and reporting of data required by internal and outside agencies.

Clinical and Operational Transformation (COT) processes have been around for years, but not until recently have organizations embraced the concept for ambulatory physician offices. Deciding to adopt an EHR is one of the most important decisions made by any practice. The transition to an EHR from a paper system can be challenging due to the fact that it will change the way everyone works. EHRs can change current documentation method(s), workflows, billing practices, scheduling, patient follow-up methods, communication, messaging, etc. EHR adoption usually requires re-engineering current systems and can dramatically change the way practices run. Considering the vast changes that have to happen to adopt an EHR, extensive planning must occur for a successful implementation.



We believe we can establish a base-line approach towards optimization and we will be able to provide your practice with guidelines for EHR implementation success. We provide each organization with an operational plan based on the following phases:

A. Planning Phase:

- As the saying goes "Fail to Plan, Plan to Fail" and isn't that the truth. The planning phase is the most extensive and time consuming phase of the implementation process. The planning phase provides a great opportunity to map out the entire process which may include planning the following: conversion of data from the paper charts and what information to convert, current workflow analysis, redesigning new workflows for the EHR, deciding on methods of documentation (template creation, voice recognition, voice capture, partial dictation), staff training strategies, software testing, hardware testing (whether to consider using mobile devices and wireless technology), security rights and authorized access and system piloting. EHR adoption should be an evolution, not a revolution, and with proper planning you can get your EHR up and running smoothly with a minimal amount of staff frustration and loss of productivity.

- **Identify goals and base your planning strategies around these goals**. First identify broad goals for the EHR and then develop more refined goals. Examples of broad goals may be: to identify and follow-up all patients who are not meeting the preventive health maintenance guidelines; analyze patient profiles based on demographics; create a referral tracking system; create tight security controls to reduce the risk of compromising the integrity of the chart; ensure that the hardware configuration will allow the provider to maintain eye contact with the patient, etc. Identify specific areas within the EHR to reach goals successfully. Share all goals with the staff as well.

- **Decide what data needs to be retrievable:** It is common for practices to begin entering data into an EHR only to discover that the data is in a non-reportable format, not consistently entered, or not entered in any standardized manner by all providers. Therefore, this data is not reportable or incomplete, rendering it useless for queries. Identify what data will be useful for reporting purposes, such as certain diagnoses and medications prescribed per physician; graph of BMI in a pediatric population after a pediatric exercise program was introduced; incidence of tobacco use within the patient population; diabetic patients who have not received an HbgA1c in a specified period of time, etc.

- Your pre-determined goals and data that you want captured for reporting purposes should drive the decisions made during the planning phase. Utilize this information to create customized libraries, pick-lists, standardized and/or required data fields that everyone will use consistently for desired reportable information. Ask the vendor how data in certain areas of the system is stored and ask if this data is reportable in that format.

- **Be aware that "Free Text" may not be reportable**. For many EHR programs, if the data is not in discrete data fields, the information cannot be captured by an internal report writing program or a third-party report writing program. Utilizing a fully-integrated speech recognition software program within the EHR, which captures voice dictated text, is in a free-text format as well, and therefore may be non-reportable. There is a growing trend in the industry at utilizing artificial intelligence to attempt to capture free text as discrete data usable by the EHR for reporting. This functionality may be available in the not too distant future.

- **Phased implementation is highly recommended.** Most EHRs lend themselves well for phased implementation because many of their functions are in discrete modules such as lab order entry, messaging, E&M coding, preventive health maintenance, patient tracking, e-prescribing, etc. If a phased implementation is chosen, map out the phasing and rationale for the order of implementation. The staff will appreciate adding additional modules after they have adequately digested previous modules.

- **Create timelines but be flexible.** Timelines are great tools for project planning but be aware that they must constantly be re-evaluated, especially if you are designing time lines for phased implementation. Keep assessing progress as the implementation process moves forward, and ensure staff that time lines are adaptable to current situations to help reduce their stress level. Entire implementations including training can span a couple of weeks for small practices (1-2 physicians) to several months for larger practices.

- **Perform a workflow analysis:** Analyze existing work processes while looking for opportunities for improved productivity and efficiency. Design new work flows that could be accomplished with the tools available in the EHR and develop a transition plan.

Staff Considerations and Planning:

- **Appoint a Physician Champion.** A physician champion can be instrumental in the success of the EHR adoption. This person should be motivating, enthusiastic, have a good working knowledge of the EHR and be able to articulate the specific benefits that the EHR will provide.

- **Appoint an in-house Project Manager.** Most vendors will supply a project manager for large group installations but in addition, have a key person on staff to oversee the entire project. This person should have extensive knowledge of all areas of the EHR as well as how the EHR will interact with each type of provider and support staff. This person is crucial for the "Big Picture" viewpoint and to know the rationale for decisions that are made.

- **Communicate to the staff the practice's desire to acquire an EHR before the purchase.** Better yet, include them in the decision of which EHR vendor to choose. It is common for a physician to choose an EHR with no input from the support staff. This can create a feeling of resentment among staff and a feeling that their input is not useful or necessary. The staff will more likely embrace a system that they have had input in choosing, and will then be more acceptable to the adoption.

- **Be aware that support staff may feel that they could be replaced by an EHR.** In certain cases this may be accurate particularly with file clerks or other types of staff; be sensitive to this possible concern.

- **Have end-user staff involved in the system set-up.** Many times practices rely on only one person to set-up system files, pick-lists, defaults, templates or libraries, customizable options etc. This presents a problem in that only one person has an understanding of the rationale for the decisions that were made at that time, and that knowledge will be lost if that person leaves the practice. It is best to utilize the end-users for system set-up decisions because they are the ones who will be performing the tasks that the system parameters will affect. They have the detailed knowledge of present procedures and workflows and therefore may know ramifications of such system set-up parameters on other functionality.

- **Map out Workflows utilizing current staff members:** Map out current workflows on paper and bring in the end-users who perform the current workflows to help design new workflows for the EHR. No one knows their job better than the person who does it everyday but more often practices do not go to the source for this crucial input.

- **Learning curves are usually underestimated.** The learning curve for complete and successful adoption of the EHR is usually vastly underestimated. Even if productivity is not affected initially during the go-live phase, most providers do report an increase in the length of time necessary for documentation, especially if templates are used and the providers are not familiar with them. Most providers will spend additional time at the end of the day documenting notes after a go-live. Usually within 6 months to one year, most providers are leaving the office at their normal times. It is difficult to predict length of learning curves and the impact of learning curves on productivity. Utilize the vendor's knowledge for benchmark learning curve estimates.

B. Testing phase:

Software/Hardware Testing:

- **Test software extensively before implementation.** Never assume that the software functions in the way you think it should. Set up a test database for software testing and for staff training. Thoroughly and completely test all areas of the software and utilize the end-users to test their specific functions.

- **Perform Volume testing, if possible.** Take a typical day and do a dry run in a test database. This step is often overlooked but can provide important information regarding the time it takes to enter data with typical volume or increased volume.

- **Ask for a list of known bugs from the vendor for the version you are about to install.** If bugs exist, ask the vendor to create work-arounds and identify dates for patch fixes. You do not want to identify a major system flaw or bug during the go-live phase when this could be prevented.

C. Training Phase:

- **Not enough time is allocated for training**. This is a very common error made by most practices. Keep in mind that not only is staff required to learn the EHR but also new workflow and procedures. Training sessions are best if kept short and scheduled in increments. Small groups are more beneficial for more personalized training. Allow staff to practice what they have learned using a hands-on approach before introducing new information. Utilize the vendor's experience with training time, but be willing to alter for your individual practice.

- **Training should be performed outside of clinical work sessions.** Practice administrators, in their concern to not adversely affect productivity, will attempt to train staff as they try to perform their clinical duties. This leads to poor understanding of the software and frustration. Train users correctly the first time. There are several methods that practices can utilize to effectively train staff such as reducing or blocking schedules, hiring temporary employees, training outside of clinical time. Staff should also be paid if they are being trained outside of their usual work schedule.

- **Set up a training room for staff to practice.** Giving staff time and a quiet location to practice can lead to a comfort level with the software and can lessen the apprehension of go-live.

- **Appoint SuperUsers.** Designate certain users to be "SuperUsers". Their role is to provide immediate first line response to staff with questions and issues during go-live. Designate a super user for each type of clinical role (MA, nurse, receptionist, provider). SuperUsers should have a more extensive knowledge of the software and workflows. Being able to provide immediate support to staff during a go-live situation will more likely ensure that productivity is not interrupted.

- **Miscommunication risk with Train-the-Trainer method.** One concern with Train-the-Trainer methods is the potential miscommunication and/or misunderstanding of information from one person to another. Trainers supplied by the vendor

usually train large groups of users simultaneously and are more experienced with training on the software. Train-the-trainer methods can provide a cost savings to the practice, however.

- **Evaluate staffs' readiness for go-live.** Assess staff knowledge of the software and workflows. Create mock live situations and walk-through the workflows considering all possible scenarios. Be prepared to delay go-live if the staff is not sufficiently prepared.

D. Go-Live Phase:

- **Schedule the go-live in close proximity to the end of the training sessions.** Try to avoid a long delay between the training sessions and the go-live. No more than a week should be allowed between the end of training and the go-live. This will ensure better retention of the information.

- **Reduce provider schedules:** Reduce the number of patients a provider is required to see during the go-live phase. Learning an EHR can be a difficult process, especially for providers. Reducing schedules for some period of time can reduce the pressure significantly. Many practices reduce schedules by 50% for one to two weeks after the go-live and then 25% for several additional weeks. Another method that has been used is to add 15 minutes on to comprehensive examinations and 5 minutes on to follow-up visits. Note: this method may involve some planning ahead to accommodate the scheduling templates.

- **Provide Adequate Resources.** Be certain to supply the staff with well trained individuals such as vendor trainers, SuperUsers, in-house project manager, etc. during the go-live phase. Create a Help Desk Hotline in case trained personnel are not immediately available. Communicate the chain of support method to all users before go-live. Put a sticky label on each PC with the Help Desk Hotline phone number. Have systems in place if bugs or issues are discovered.

E. Post Go-Live

- **Post Go-Live Assessment is necessary:** Now that the EHR has been implemented, many practices feel as though the installation is complete. However, nothing could be further from the truth. Practice administrators must continue to assess the staffs' level of frustration, monitor productivity, measure patient cycle times, re-evaluate workflows, assess learning curve, and determine whether the EHR is meeting the established goals.

- **Evaluate the Go-Live with Staff:** Query the staff regarding the go-live process. Get their feedback as to what was helpful and what was lacking. This information can help with future implementations especially if new modules are to be introduced in the near future.

- **Provide on-Going training and support:** Practice administrators should continue to offer training sessions well after the go-live for reinforcement and refreshment. Staff usually can not absorb all the information given during the initial training sessions, and therefore follow-up training sessions should be offered.

Best Practices

When it comes to clinical and operational transformation, healthcare organizations need to identify best practice solutions to various operational workflow issues and clinical concerns. To assist practices, AC Group has come up with numerous questions and best practice alternative solutions that practices should consider before beginning the implementation process.

1. How do you determine if your new EHR has improved clinical charge capture?
2. What types of end-user workstations are best for your staff and for the physicians?
3. With numerous implementation options, which option is best for your practice?
4. What patient demographics, billing, and clinical data do you want to import from your current electronic systems?
5. What patient demographics, billing, and clinical data do you want to import from your current paper systems?
6. What data and customizations do you need for the Physician Dashboard template?
7. What data and customizations do you need for the Patient's Summary Page?
8. What data and customizations do you need for the individual clinical templates?
9. What data and customizations do you need for Health Maintenance alerts and P4P reporting and tracking?
10. What are the benefits of using an e-Patient Portal and are the benefits worth the costs?
11. How will the new system affect Patient Appointment Scheduling and are there new workflow techniques that can improve appointment time compliance?
12. How will the new system affect Patient Registration and would an e-registration program reduce costs and improve data capture?
13. How will the new system affect Patient Eligibility Checking via batch and real-time transactions?
14. Given the selected EHR product, will you need to change the check-in and check-out processes?
15. Given the selected EHR product, will you need to change the payment collection process?
16. Given the new automated workflow processes, how would you like to handle Release of Information reporting?
17. Given the new automated workflow processes, how would you like to handle Incoming phone calls, tracking, and auto routing of calls?
18. Given the new EHR product, how will changes in technique in capturing Family History, Social History, Current Medications and other data affect workflow and clinical data capture?
19. Given the new EHR product, who and how will ROS and HPI data be captured? Pre-captured and populated by the patient, the nurse/MA, or by the physician?
20. Given the new automated workflow processes, how would you like to handle Lab ordering, tracking, and Results reporting ?
21. How will the new system affect your Physician Documentation Processes?
22. How will the new system affect your Physician ePrescribing processes and will you need to change your processes now that you have automated tracking of formulary compliance, drug alerts, and eRX transmissions?
23. How do you want to handle automated updating of patient-specific eRX medication profiles based on community physician's eRX orders?
24. What modifications are necessary to use the EHR's patient education modules?
25. What modifications are necessary to use the EHR's patient take-home clinical note?
26. What modifications are necessary to use the EHR's referral letter format?
27. How will the new system affect patient Check-out?
28. How will changes in the new system affect Patient Statement processing along with Insurance claims processing and follow-up?
29. What type of reports need to be set up in order to meet all of your reporting requirements?

Every practice must consider best practices and recommendations towards "clinical and operational" transformation. They assume that the vendor will implement and train, but practices want and need someone to help design the system, policies, and procedures around best practices.

Staffing: The following staff will be assigned to work on your project:

Proposed Staff	Name	Experience in Healthcare	Experience with Ambulatory Offices	Experience working with EHRs
CEO	Mark Anderson	34 Years	12 Years	7 Years
Senior Consultant	Lorraine Casagrande, RN	30 Years	10 Years	2 Years

The project will be lead by Mr. Mark R. Anderson, CPHIMS, FHIMSS, CEO and Healthcare IT Futurist with AC Group, Inc. Mr. Anderson is one of the leading national speakers on technology in healthcare and has spoken at over 350 conferences and meetings since 2000. He has spent the last 32+ years focusing on Healthcare – not just technology questions, but strategic, policy, and organizational considerations. He is a widely-versed individual whose line and consulting responsibilities in more than 200 hospitals, 50 healthcare payer organizations, and 70 Physician/Clinics has provided him with a wealth of front-line experience. Mr. Anderson was also the CIO for a 3,000 physician, 500+ practice-based IPA located 90 miles north of NYC. Therefore, he is experienced working directly with small physician groups.

Pricing is based on the number of providers (Physicians and PA's)				
Providers	On-Site Hours	Off Site Hours	Total Hours	Proposed Fees
1 to 3	26	28	54	$ 5,000
4 to 9	35	38	73	$ 7,000
10 to 19	47	51	98	$ 10,000
20 to 49	64	69	133	$ 15,000
50 to 99	86	93	179	$ 20,000
100 to 149	117	126	242	$ 25,000
150 to 199	157	169	327	$ 35,000
200 to 299	212	229	441	$ 45,000
300 to 399	287	309	596	$ 55,000
over 400	387	417	804	$ 75,000

Payment Schedule

A down payment of **30%** is required along with the signed agreement by the agreed upon effective date. An additional 30**%** is due after the completion of initial Super User training and product configuration. An additional 30**%** is due 15 days after go-live. The **remaining balance** of 10% will be billed 90 days after go-live.

Checks are to be made payable to AC Group, Inc. If there are any questions concerning this agreement, please contact AC Group at (281) 413-5572 or by mail at:

AC Group, Inc.
118 Lyndsey Drive
Montgomery, TX 77316

AC Group, Inc. Tax ID #: 61-1313700

Why select ACG:

We offer clients the advantage of the finest industry research available anywhere, as well as a resource equally valuable -- the collective hindsight of hundreds of companies whose IT experiences we have monitored and analyzed in detail. AC Group can increase the effectiveness of your healthcare IT programs by providing recommendations for improving your organization's ability to address industry trends, market drivers, and new competitive threats. ACG is qualified to deliver these services based on:

- Our knowledge of the healthcare IT marketplace enables us to accurately analyze that market, taking the competitive landscape and industry drivers into consideration.
- Our understanding of user buying dynamics via our ongoing syndicated research services with provider, payer, and vendor organizations. ACG leverages existing research and opinions formulated through extensive user interaction to provide timely analysis and real-world experiences.
- Our use of acknowledged healthcare IT industry experts gives us credibility in presenting our findings and recommendations to your senior management.
- ACG's staff experience working with and in Provider and Payer organizations for 30+ years. We are not just researchers, we are former executive members of multi IDN's, Physician Groups, and Payer organizations, and thus, our staff represents the peers that you would be working with.
- Combined with our experience performing IT strategy engagements, ACG is well positioned and excited about assisting your organization on this initiative.

For the last three years, ACG has produced an annual report on the Digital Medical Office and the use of Technology by physicians. This comprehensive report includes detailed reviews of the Mobile Healthcare, Document Imaging, and EHR marketplace. The report also includes the most comprehensive evaluation of vendor EHR functionality to date - more than 5,000 questions. The founder, Mark Anderson, speaks all over the country and in Europe on the "Incremental Approach" towards physician office automation and encourages practices to move into the EHR marketplace "incrementally".

Acceptance
On behalf of the AC Group, we look forward to assisting you and your practice in the healthcare marketplace. Please indicate acceptance by signing below and returning by fax to **1-832-550-2338.** Approved by Name: _____ Company: _____ Approved by Signature: _____ Date: _____ Approved Contract Amount: _____

The conditions and prices in this proposal are in effect for one month from the date of submission. Please review the attached document; feel free to contact us if you have further questions. Mark Anderson can be reached at his Houston office at (281) 413-5572 or by e-mail at mark.anderson@acgroup.org.

Respectively submitted:

Mark R. Anderson, FHIMSS, CPHIMS
Healthcare IT Futurist
CEO, AC Group, Inc.

Mark R. Anderson, CPHIMS, FHIMSS

CEO and Healthcare IT Futurist

AC Group, Inc.

e-mail: mark.anderson@acgroup.org

Mr. Anderson is one of the nation's premier IT research futurists dedicated to health care. He is one of the leading national speakers on healthcare and physician practices and has spoken at more than 350 conferences and meetings since 2000. He has spent the last 30+ years focusing on Healthcare – not just technology questions, but strategic, policy, and organizational considerations. He tracks industry trends, conducts member surveys and case studies, assesses best practices, and performs benchmarking studies.

Besides serving at the CEO of AC Group, Mr. Anderson served as the interim CIO for the Taconic IPA in 2004-05 (a 500 practice, 2,300+ physician IPA located in upper New York). Prior to joining AC Group, Inc. in February of 2000, Mr. Anderson was the worldwide head and VP of healthcare for META Group, Inc., the Chief Information Officer (CIO) with West Tennessee Healthcare, the Corporate CIO for the Sisters of Charity of Nazareth Health System, the Corporate Internal IT Consultant with the Sisters of Providence (SOP) Hospitals, and the Executive Director for Management Services for Denver Health and Hospitals and Harris County Hospital District.

His experience **includes 34+ years working with Healthcare organizations, 22+ years working with physician offices, 7 years in the development of physician-based IPAs, PHOs, and MSOs**, 17 years with multi-facility Health Care organizations, 15 years Administrative Executive Team experience, 6 years as a member of the Corporate Executive Team, and 9 years in healthcare turnaround consulting. Mr. Anderson received his BS in Business, is completing his MBA in Health Care Administration, and is a Fellow with HIMSS. Additionally, he serves on numerous healthcare advisory positions and has developed programs including:

- Developer of the Six-levels of Healthcare IT for Hospitals and the Physician Office
- Researcher and producer of the 2002-2008 PMS/EHR Functional rating system
- Advisory Board and Content Chairman – Future Healthcare, 2007-08
- Advisory Board and Content Chairman – Physician and Hospital Bonding Summit, 2008
- Advisory Board and Content Chairman - Healthcare IT Outsourcing Summit, 2002-08
- Advisory Board and Content Chairman - Patient Safety and CPOE Summit, 2002-06
- Advisory Board and Content Chairman – Consumer Driven Healthcare Conference, 2003, 2004
- Advisory Board and CPOE Chairman - Reducing Medication Errors, 2003, 2004, 2005
- Advisory Board of TETHIC 2003, 2004, 2005
- Advisory Board of NMHCC 2000, 2001, 2002, 2003, 2004, 2005
- Advisory Board of TCBI Healthcare Conference 2000 - 08
- Advisory Board of TEPR and MRI, 2000-08
- Past President of Local HIMSS Boards – Houston, Tennessee, Southwest TX
- Editorial Board of Healthcare Informatics 2001 - 06
- Judge, MSHUG ISA, 1999-2005, TEPR Awards, 2001-2002, TETHIE 2003-05, HDSC 2003-05
- National HIMSS Chapters Committee 2001 - 04
- National HIMSS Fellows Committee 2001, 2002, 2004
- National HIMSS Programs Workgroup Committee 2001, 2002, 2003, 2004, 2007
- Chair HIMSS HIE Education Task Force - 2007-08
- Member of HIMSS RHIO Best Practices - 2007-08

Implementation Oversight and Clinical and Operational Transformation Services

Lorraine Casagrande, RN - Research Analyst
Dallas, TX Office
LJC@acgroup.org
Phone: 281-413-6706

Lorraine Casagrande is a Research Analyst, based in Dallas, TX specializing in Electronic Health Record and Clinical Information System markets. Lorraine has spent more than twenty years working with healthcare organizations in the planning, implementation, and operations of Information Technology to support core business objectives.

Prior to joining AC Group in 2004, Lorraine spent 8 years with Accenture (formerly Andersen Consulting) as a Business Operations Consultant and Senior Research Analyst in Application Management. Prior to Accenture, Lorraine served as Project Leader in leading Pennsylvania and Texas hospitals installing applications from ADT/Financials and HIS through Bedside Documentation systems.

Educational background includes Washington Hospital School of Nursing, The Pennsylvania State University, and Computer Systems Institute. Lorraine worked in Medical-Surgical Nursing and Psychiatry previous to her Information Services career.

Lorraine analyzes competitor vendors within the healthcare ambulatory EHR market (electronic health record):

- Selection, implementation status, and strategic planning sessions
- EHR education sessions and application demos
- Healthcare organization panel discussions
- Clinical and Operational Transformation

Lorraine investigates and evaluates healthcare technology industry trends. Lorraine participates in education sessions and conferences across the country to advance knowledge in the information technology market

More about AC Group:

AC Group, Inc. (ACG), formed in 1996, is a healthcare technology advisory and research firm designed to save participants precious time and resources in their technology decision-making. AC Group is one of the leading companies, specializing in the evaluation, selection, and ranking of vendors in the PMS/EHR/EHR healthcare marketplace. Twice per year, AC Group publishes a detailed report on vendor PMS/EHR functional, usability, and company viability. This evaluation decision tool has been used by more than 5,000 physicians since 2002. Additionally, AC Group has conducted more than 100 PMS/EHR searches, selections, and contract negotiations for small physician offices to large IPA since 2003.