

IMPLEMENTING EMRs IN THE PRACTICE SETTING

PART 1: SMALL PRACTICES

Editor's Note: Since its inception nearly three years ago, *HONI* has been covering electronic medical record systems (EMRs) and their role in improving patient care and health facilities efficiency. EMRs not only improve patient safety by limiting adverse drug events, but also can save practices money by capturing billing and saving caregivers' time.

HONI published an article in the February issue ("What's it worth? Oncology Electronic Medical Record and ROI modeling") that detailed how practices can determine the return on investment (ROI) of adding an EMR. Previously, we published a two-part series about the efforts M.D. Anderson Cancer Center undertook to add an EMR (see *HONI* September 2002 and February 2003). This series examined some of the challenges of implementing an EMR in a large cancer center.

While all of this coverage has been very informative, we realized by talking with people in the industry that there had been very little coverage about the unique challenges of buying and implementing EMRs in the private practice setting. To remedy this, we are initiating a three-part series in this issue of *HONI* that examines adding an EMR from the point of view of the private practice.

Many practices have not yet begun using an EMR. Estimates of the percentage of private practices that use an EMR average under 10%. Yet, at a recent roundtable forum at the Administrators in Oncology/Hematology Assembly (AOHA) meeting in San Diego, the majority of participants indicated that they would be adding an EMR in the next few years.

This month we begin the series by talking to a doctor in a solo practice. In the months that follow, we will be speaking to doctors in medium and large private practices.

Horizon Oncology Center in Lafayette, Ind., is a solo practitioner office. Dr. Wael Harb has about 17 patients a day on his schedule. The practice employs three oncology certified registered nurses (RNs), with another RN about to be certified, and a licensed practical nurse (LPN). Our conversation with Dr. Harb follows.

HONI: What drove you to consider an EMR in the first place?

Dr. Harb: The world of oncology is fast-paced, bringing a lot of new challenges in different fronts. The first front is that there are a lot of new, different drugs becoming available, which is good news for all oncology patients. But it makes it even more difficult to keep track of them, trying to teach your staff about the new drug and doing patient education. The other front is that the reimbursement world for oncology continues to get more complicated and presents new challenges. This makes it imperative for oncology offices, whether they are small practices or large groups, to be very efficient and to be able to continue to deliver the same level of care with a lower reimbursement and, ultimately, give the level of care that we believe our patients deserve.

These challenges are difficult to tackle, and I think that as a solo practitioner I was seeing all these changes happening and did not want to end up deciding one of these days to quit my practice. I wanted to be prepared for any more difficulties down the road. Although some might consider EMRs a luxury today, in the near future it will be imperative for any medical practice, but especially for oncologists.

HONI: How did you justify the cost of adding a new system?

Dr. Harb: You have to consider that in oncology we deal with very expensive drugs. That makes it much different from other medical subspecialties, like internal medicine, where they mainly bill for office visits and evaluations. In oncology, we're dealing with chemotherapy drugs—infusion, the cost of

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the drug, the cost for the chemotherapy administration procedure—any mistake in this process is very costly. Any mistake in delivering the wrong drug or the wrong dosage, or not having the drug available is very problematic. When you have an EMR, you are able to track these things much easier and you will be able to have a safer environment for patients in the practice.

These drugs are expensive, so while the safety issue is important, the lost revenue issue is also crucial. It is easy to miss any charges from these drugs; this can happen frequently in oncology. Although every office has a system to track down the charges, the statistics say that even in the best practices, you are only billing 95% of what you should be billing because of missed charges. In a fast-paced practice where the patient might be added to the schedule on the same day, or the nurse has forgotten to document the treatment that was given, it is not an insignificant loss for the office.

So, yes, up front it is a lot of expense, but even for a single practitioner office such as mine, in about one to two years, you'll be able to offset the up-front charges. Then after that, you probably make the office more efficient and bring in some lost revenue.

HONI: What research did you do before deciding on an EMR system?

Dr. Harb: At various medical conferences like the annual American Society of Clinical Oncology (ASCO) meeting, I was able to preview the different EMRs that are available specifically for oncology. But I also had a chance to look at other EMRs that were not specific to oncology. I realized very quickly that it is very difficult to implement an EMR that is not made specifically for oncology. Oncology has a lot of details related to chemotherapy regimens and plans, and tracking the drugs through multiple layers of authorization to ensure safety for patients—not getting the wrong dosage or the wrong drug. The generic EMR made for internal medicine, for example, does not have all these things built in. It could potentially be done, but it would take a lot of effort, especially for someone like me who is a single practitioner. I don't have the time to devote or the revenues to develop the specific templates. I needed something that had already been tested, had already been built for oncology. That made the list much shorter. It made it much easier to make a decision.

HONI: What did you do to prepare for implementation of the EMR?

Dr. Harb: Implementation is a crucial part of adding an EMR in the office. Before obtaining an EMR, I would advise any oncologist to outline for themselves what exactly they need the EMR for. To have an EMR is exciting, but if the needs are not outlined, you might not end up, after all the costs and all the efforts, with the system that works for you.

After having the objectives clear, the implementation process is very costly. The cost of taking the staff away from their normal jobs to do all the training is significant, but from day one, I think the staff sees the benefits of using an EMR from the time the system goes live. The implementation needs to be planned well because you would like to ensure that your

staff, including yourself, has plenty of time to be familiar with the system. And any system needs to be optimized and customized to work for you. Every practice has its own different style of taking care of patients or the sequence of events in the office, and there is no EMR that will fit your needs exactly. Unless you spend the time and effort to customize it, you will find that this is not what you wanted. Luckily, most good EMRs have customization features that allow you to make the EMR fit your practice.

HONI: Did you find any resistance among staff to implementing an EMR? Did you attempt to get staff buy in?

Dr. Harb: Luckily, I had a staff that was very enthusiastic and very helpful. I have 10 medical staff in my office; two were familiar with EMRs, some were familiar with computers in general, but others had very limited experience with computers or EMRs. This is a new challenge because you would like to bring everyone up to speed and to the same level to be able to implement the change. When you are moving from paper charts to electronic charts, you are not only changing the chart, but you are also changing every single process in the office—from checking the patients in to ordering the tests, documenting the medical record, and administering the treatment. Every single process in the office will be changed. Even if the change was not as drastic from changing from a paper chart to an electronic chart, any change to the office takes some time and effort for the staff that has been using a certain style for awhile.

What helped in our office was that I held weekly meetings with my staff, one hour each week, before we even started the training. This helped to get them familiar with the system, to discuss what issues they had, and what anxieties they might have. That helps a lot in getting them prepared for the next step. This weekly meeting also helped to identify the problems early so we could address them and make the process of implementation smoother. I think that is essential.

HONI: So, in a sense, the “pretraining” made the implementation process a lot smoother. Were there any problems with the implementation?

Dr. Harb: I wouldn't believe that any implementation would occur without obstacles. Some of these obstacles are technical, some of them are trying to customize the system for your needs, and some of it is the need for additional training after the initial rollout. Although you go through training and think you have learned all the processes, you go back and find there are areas that you or your staff members have not absorbed, and they need to be retrained in these areas.

I would be lying if I said that the implementation process always went smoothly. From my experience, there will always be some problems. But knowing that we wanted to add this system and that the system would make the practice more efficient made us able to better deal with these obstacles, to solve the problem and move on.

So in looking back, it was a difficult time, but when looking at where we are at right now, we realize how much improvement we have made from the previous system.

HONI: How long did it take you and your staff to get comfortable with the new system?

Dr. Harb: The EMR has a lot of different facets. There is the scheduling and check-in process, the charting process, the electronic record, the chemotherapy ordering, and so on. All these different aspects of the EMR are not the same, and you don't have to implement all these processes at the same time. That was one thing I learned. It might be easier, and we found it this way with our staff, to implement it in stages. So in our practice, we started with the scheduling. We have not moved to electronic charting yet, but at least for the first step we were able to have all patients transferred to the new schedule and that helped us to learn on the system and get comfortable with that part. Then for the next step we will be able to do the chemotherapy ordering. We will then be able to do all the electronic charting, followed by the recording of all my notes and dictation. But that process has not started yet.

We are now working on the scanning and being able to load faxes into the system. Our goal is to get to a paperless office. For an EMR to work well in an office, the whole process needs to be electronic. If you are still using a dual system, then you have not gained all the advantage of moving to an EMR. That is very important.

Relatively speaking, it was a shorter process than I expected. Each component took about two to four weeks to implement to the point where we feel very comfortable with the new process.

HONI: Have you seen benefits already as a result of using the EMR?

Dr. Harb: Yes. It depends on which process you are talking about. From day one when we went live, the nurses were already seeing some efficiency in doing their notes and documentations by being able to do them right away when they were fresh in their minds. So from day one, the nurses saw more efficiency.

Right now we are customizing and optimizing the parts where I do my charting for my patient notes. I have noticed a significant improvement where I am able to do a significant part of my notes electronically, and that has cut down on the amount of dictations that I am doing. I think every physician will find which style works best—some may decide to do no dictations, some might continue to dictate, and some might use a hybrid system, which is what I do, and I find that this gives me more time to spend with my patients and give them better care.

HONI: Are your staff members seeing benefits?

Dr. Harb: They are seeing that we have a safer system for our patients. We are able to respond to problems more efficiently. We can track information better, when a patient calls in, for example. Every day I hear from my staff members about how much they like the system and how much they are realizing as they are learning, that they are finding different ways to do the same processes and to optimize their time and make them more efficient. But overall the process is gradual, continuous improvement. For any office to see the full benefits, it needs to work with the system for at least six months. We are at about two months, but it is very encouraging even at this early stage of implementation that we are already see-

ing significant improvements in a lot of different areas.

HONI: What would you recommend to other single practitioners considering adding an EMR?

Dr. Harb: They must identify the reasons they need the EMR and make sure that the EMR they are choosing will fit these needs because it would be very difficult after going through all this process to realize that they have not achieved their goals. Some goals might be realistic and achievable with an EMR, while others might not be. An EMR that might fit one physician's needs might not work for others. It is very important to get familiar with the systems and get familiar with the objectives. The best way to do this is to get hands-on experiences, either by visiting other offices that have the system or visiting any booth at a conference such as ASCO or the American Society of Hematology where they have the system set up. They need to spend a lot of time working with it hands-on to see if they feel comfortable using the system.

One of the major things that would prevent a single practitioner office from obtaining an EMR is the cost. I think, especially for oncology, if you do your analysis, and just by using a conservative estimate of losing 5% of billing over a year, you realize quickly by making up that difference, you'll be able to offset the cost of the system in about one to two years. After that, you will be able to become more efficient with your revenue stream. ■