



# Implementing EMRs in the Practice Setting

## Part 3: Large Practices

**Editor's note:** This article is the final installment in *HONI's* three-part series to examine implementing an electronic medical record system (EMR) in the practice setting. This month we spoke to Mike Koroscik, COO, of Oncology Associates, a large, multi-site practice in Wisconsin. That interview is the first part of this article below.

We also spoke with Diane Mulkhey and Renee Courtemanche of Central Maine Medical Center in Lewiston, Maine. Although this comprehensive cancer center is more of a medium-sized practice, it has implemented an EMR extremely quickly and brings some interesting insights to the implementation process. Their interview follows Mr. Koroscik's.

### ONCOLOGY ALLIANCE

*Oncology Alliance has 26 physicians, split relatively evenly between medical and radiation oncology. They have 11 medical oncology sites and 9 radiation oncology sites geographically dispersed in southeastern Wisconsin.*

**HONI:** What prompted you to consider an EMR?

**Koroscik:** We really wanted one coordinated, single system for a wide geographic distribution of clinics. Before, we were dealing with paper and so forth. We wanted to have something where we could go to one source, be able to pull up the information and so forth, and not amass so much paper.

We would have to carry the charts from one office to another.

Basically we added an EMR because we knew we wanted to grow our group. It was single physicians who came together because they saw the benefits of being part of a larger group. One way we knew we had to be different from all the rest was in choosing an oncology-specific EMR system.

**HONI:** What did you research for choosing an EMR system?

**Koroscik:** We have been with our current vendor a long time. We were actually a beta site with this vendor. So there wasn't a lot out there at the time that was oncology specific when we first started looking. We had looked at some general systems, but as I said, at the time there weren't a lot of options, so we really couldn't do a lot of research. That's one of the reasons we decided to be a beta site for the vendor.

**HONI:** Once you had the system, what type of training did you do?

**Koroscik:** We trained the physicians first. We wanted to make sure we got them on board, especially the ones who were not very computer savvy and were most resistant. We wanted them to buy in. After that, it's a much easier sell down the line. So we started with the physicians and moved down through the clinical staff.

**HONI:** You mentioned resistance. Was there a lot of resistance to an EMR?

**Koroscik:** Sure. Change is a jagged pill to swallow. It was something new, something different. We were the first in the area to utilize an EMR. So it was just that sort of resistance to change.

**HONI:** Were there any specific challenges because you are such a large clinic spread over so many different locations?

**Koroscik:** The biggest challenge has been trying to move to a paperless environment. Part of the challenge was really an opportunity. As these independent physicians came to join a group, they saw the power of using an EMR. The challenge was saying, how do you actually do this. We've amassed all these paper charts and so forth, so how do we separate these out and move to an electronic system and away from paper?

Where we've found the most success in this so far is a brand new radiation oncology department we just opened. We ordered the vendor's system for radiation, where they've had much more experience. But, because we built it from scratch, it was much easier to start a brand-new center that was paperless right from the get-go. The challenge on the medical oncology side is to become paperless after you have dealt with paper so long.

**HONI:** How is the implementation going?

**Koroscik:** We all share the vision of eventually getting to a paperless office, and it's the common goal. We break it down into a weekly committee. We work with the IS [Information Systems] department and the clinical staff and take it in pieces. It's not something you can do overnight. You realize what you can and can't do. In reality, our goal is not to become completely paperless. There are offices where faxes are downloaded and so on. It's truly no paper. For us, paper will exist, but we want to make sure we can scan things and, as much as possible, make sure everything the physician needs is in the electronic file.

**HONI:** What results have you seen since using the EMR system?

**Koroscik:** We have utilized the data tracked by the system for managed care contracting and measuring quality outcomes. One of the benefits of being a beta site is that the vendor really listened to our recommendations for improvements because it was so new to medical oncology. A lot of the changes we suggested early on have been realized.

**HONI:** Has billing improved?

**Koroscik:** It has, but our practice management system does not use that piece of the EMR. So we had to build an interface between our practice management system and the EMR.

**HONI:** Do physicians see the advantages of finding the chart in one place?

**Koroscik:** Yes, they do. We are still evolving. For example, there is something in our system that does dictations and that is just starting to be utilized by all the physicians.

**HONI:** Other people I have talked to have found that, at first, physicians feel that doing their own notes is taking up time doing secretarial or administrative type work. Have you experienced that?

**Koroscik:** That's part of the resistance I mentioned earlier. But one thing I said is that this is too expensive to be used as a scheduling device alone. It has enormous capacities. I tried to recruit

one physician who was going to be the champion of this product or part of the system. Often it was the person who was most computer-resistant in the past. Once everyone saw that this formerly resistant person had learned the system and that it really benefited him or her, they were quick to get on board and follow.

**HONI:** What have you learned along the way that you can share with other large practices in similar circumstances?

**Koroscik:** You need to get buy-in upfront from the physicians that they are going to utilize it. It's a change, but a necessary one, especially going into this new reimbursement environment. Utilize it to its full extent, and only then will you see its true value.

**HONI:** Speaking of the new reimbursement environment, do you see an EMR as something necessary to go forward?

**Koroscik:** I definitely do. To be able to measure quality outcomes and utilize the data, we're much better prepared to deal with the Medicare changes that will occur in 2005 and beyond.

**HONI:** Do you see quality outcomes becoming more of an issue with payers besides Medicare?

**Koroscik:** Definitely. It's not even just with payers, but with large business initiatives. They are measuring quality and determining which providers they are willing to send their employees to. Quality indicators are now used heavily for the business side for contracting and curbing their escalating costs.

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### Central Maine Medical Center

*Central Maine Medical Center is a comprehensive cancer center in Lewiston, Maine. It has four medical oncologists and two radiation oncologists. The center sees about 800 new cancer diagnoses a year; and the medical oncology center sees 60–80 patients a day.*

**HONI:** What prompted you to consider an EMR?

**Mulkhey:** Medical and radiation oncology are physically separated. We are in two opposite ends of the hospital. In terms of continuity of patient care, we didn't have prompt, real-time information about patients. They'd go to one department in the morning and the other department in the afternoon, and duplication would occur. You'd be using the same nursing assessment form, so what you asked them in the morning, you'd have to ask in the afternoon. We also had some issues in terms of documentation in the charts: is everything that is written included . . . those types of things. Medical oncology is a really different animal. With chemotherapy things change, so you can't write an order today for six months out. So it was really about both of those issues.

Adding a system had a huge impact on communications. We were spending too much time calling each other with questions like: When is this patient scheduled for treatments? When does he or she start chemo? Who is coordinating appointments? Now we're all on one system and can find information without having to make multiple phone calls.

Fortunately we did not have to drag physicians kicking and screaming into the world of EMRs. The physicians were

the ones driving this; they were very eager to get a system like this. Even with this support, though, we knew we would need a medical oncologist and a medical oncology nurse to help us with the clinical piece. Our clinical nurse champion, Renee Courtemanche, has been invaluable in this process. She can motivate physicians to stay current. She is well versed about their needs and how to assist them. If they give her a paper order, she works with them, shows them how to adapt their style of work.

**The site we visited seemed to take a much more fragmented approach to implementing the system. They took little baby steps. Every six weeks they'd implement something new. It was taking them quite a while to get going. One of our doctors, who was probably the least computer savvy, the one that was most hesitant in her ability to use the system, is doing fantastic with it. She said it's like teaching a baby to swim. You've just got to throw the baby in the pool, provide support, but let it figure out how to swim on its own. That's really kind of the approach we have taken.**

**HONI:** Do you think it's important for a caregiver as opposed to management to champion the system?

**Mulkhey:** It's of huge importance. Renee is able to speak in the terms that make a clinical difference. Yes, an EMR is about finances, and yes, it is about keeping everybody out of audits and all those kinds of things. Although clinicians care about these things, that's not their primary role. They are there to provide excellent patient care.

When it can be shown that the EMR is about patient care, from administering chemotherapy to making their schedules more convenient, the caregivers are very supportive. We

wouldn't be nearly successful without Renee or without Dr. Jeff Miller, our physician liaison for this effort. He went on site visits and talked to other people. So now, when he talks to other physicians or nurses, he has a lot of clout.

**HONI:** As an administrator, what are some of the results you've seen?

**Mulkhey:** We are still really early in the process. We are just about to start our first chart audit. And actually, the staff is pretty excited about it. I don't have enough information yet to say where we really are. I can tell you that phone calls have been reduced drastically.

**HONI:** What would you recommend to other oncology practices going forward with an EMR?

**Mulkhey:** We struggled about whether we were going to implement the system piecemeal and how much we were going roll out. We decided that we were going to roll out everything at once. Medical oncology really had nothing in regards to EMR. They needed a scheduling package ASAP. We created the first 20 care plans and put them into the system. We rolled out as much as we could simultaneously. I think that was a good idea. My recommendation would be to roll out as much as you can, as early as you can.

**HONI:** Reading between the lines a bit, it seems that staff buy-in is crucial to a quick rollout.

**Mulkhey:** It's essential. I don't know how you get that to happen if it doesn't come naturally. I have to tell you, though, that overall this was a very long process. We looked into this nine years ago, and at the time, no one had a good product for medical oncology. But since implementing our radiation system, we've been getting ready to do this, so it's been a five-year process for medical oncology. Maybe because it was such a long process, they got on board sooner. You do hear the complaints periodically. Some of the feedback from a couple of the physicians is, "You want me to do more non-physician work than I was doing before. I have to type in notes," and that kind of thing. They can see the value, but they feel like they are doing a little more paperwork, for want of a better description. But they turn around pretty quickly and say, "Wow, it is pretty nice that I can just click and see the latest notes." They are starting to see the benefits of not having to look for a chart.

**HONI:** Why did you choose an oncology-specific program and what sort of research did you do?

**Mulkhey:** The hospital had just bought an EMR system. We got a lot of encouragement from IS and administration to stay with that vendor, primarily because of the assumption that the interfaces would be much more adaptable throughout the hospital. We looked at the existing vendor and several other vendors. The hospital system's vendor actually pulled out of the running when they saw our needs. They asked if we wanted to be a beta site, but we couldn't wait. We did a lot of looking, site visits, requests for information. We looked at the whole package.

**HONI:** What lessons did you learn about implementation on the management side?

**Mulkhey:** One important thing to do is take user champions out of the clinical areas and give them the time to create care plans, create templates, help with training, attend meetings—do all the things needed to make the implementation successful. It is extremely difficult to do that, I realize. We should have done a better job of providing more support for Renee, so she could provide more support for the implementation. You really have to give your clinical person the time he or she needs away from the clinic to implement the product.

**HONI:** You've mentioned a physician documentation piece of the system. What is that?

**Mulkhey:** For us, the physician documentation piece is still in its infancy. And it is one area we've heard some complaints about. Physicians are used to doing their dictations and then someone else does all the transcription and gets it back to them. With this system, they have templates for their dictations, and they click on a template to create a full dictation. A little of the feedback from the physicians is, "Now you want me to do transcriptions?" I can definitely see that point of view, but the value is that it is real-time. If the patient comes here this morning and goes to the other department this afternoon, that note exists. The physician can see in real time what happened an hour ago. The benefit of the system we are using is that it is comprehensive in what it does. It doesn't do record-and-verify here and just care plans there. It integrates the entire system so you have a medical record that is useful to everybody, and you can do away with that chart.

**HONI:** Renee, what has the implementation process been like on the clinical side? What training did you do beforehand?

**Courtemanche:** We did a couple of site visits before we even got budgetary approval. That's kind of what sold us on the system itself. Then, after we were approved, we went to another site and visited with them—a couple of nurses, a couple of managers, a couple of IT (information technology) people went down just to get an overview and inform us as to how the system would work.

**HONI:** What did formal training involve?

**Courtemanche:** They first came up and configured the system. After they left, it involved a lot of work on our part to set up the libraries, the procedural libraries, the medication formulary, those types of things—getting started on creating care plans. We were focused on just getting the guts of the system in there so that, when they came back to train the rest of the staff on using the system, there was something to work with.

They came back three weeks later, which I guess was not a very long turnaround time. Most sites have at least six or eight weeks between that first system configuration visit and the general staff training visit. But because of staffing here and vacations, we really tried to stick to the three-week window, and we were able to get it done.

So they came back and did the general training for the staff, and we went live that afternoon when they were leaving.

**HONI:** It seems that you and Dr. Miller were key in implementing the system. Do you think it is important to have clinical staff so involved in the process?

**Courtemanche:** Definitely. We have four physicians here, and they all practice differently. You can't always get them to

agree on a certain way to give a certain regimen. They all have their own little preferences. When you start with a new system like this, it is virtually impossible to honor everybody's preferences. So the way we approached it was that Dr. Miller was going to be the lead person, and he was going to make the decisions, and decide how the care plans were going to go into the system. People may want to do things a little differently, and we can change plans at some point.

Everyone needs to start at the same point and then we can go from there. But that was kind of the approach we took because, otherwise, it would have been four times the task to get everything in there with everyone's separate preferences.

**HONI:** What role did the management staff play in the implementation?

**Courtemanche:** They made the regulatory decisions and the financial decisions. They have been very supportive as far as getting the drug codes entered. That process was foreign to me; because as a nurse, that's not part of my job . . . But that's something else that has been important: You try to delineate the roles of who deals with what, because it's overwhelming for someone such as myself, who's a nurse trying to tackle the administrative-type duties.

I've said I'll handle anything nursing, anything clinical, but we'll let the managers and the administrators take care of the financial part of things. Let the secretaries take care of the clerical part of things. Just make it more manageable.

**HONI:** What would you recommend to other practices?

**Courtemanche:** The site we visited seemed to take a much more fragmented approach to implementing the system. They took little baby steps. Every six weeks they'd implement something new. It was taking them quite a while to get going. One of our doctors, who was probably the least computer savvy, the one that was most hesitant in her ability to use the system, is doing fantastic with it. She said it's like teaching a baby to swim. You've just got to throw the baby in the pool, provide support, but let it figure out how to swim on its own. That's really kind of the approach we have taken. We still have a lot to learn and there is a lot we still have to tap into, but I think, as a whole, we jumped in with two feet and learned a lot. The most acute growing pain is behind us. ■

