



May 7, 2004

SPECIAL TECHNOLOGY SECTION

THE CONNECTED PHYSICIAN

Getting an EMR Up and Running

The right approach for you depends on a number of factors. Know what you want and design a road map to get there.

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Family Physicians of Central Jersey in Freehold, NJ, has had a NextGen electronic medical record system for the past six years. With 11 family doctors and internists and six NPs scattered over five offices, the group has used the EMR not only to better manage data and workflow, but also to tie the doctors together. Consequently, all the clinicians participated in making changes in the note-taking templates.

"We tried to merge everybody's practice style by doing it together," says FP Ken W. Faistl. "This allowed us to use the same kind of chart documentation for the same E&M codes. We eliminated differences between what we were charting and what we were billing."

The group also decided not to link the EMR with its billing and scheduling system. Even though the practice management system was old, it worked well, the staff was used to it, "and I didn't want to disturb my cash flow," says Faistl. Because the practice didn't link the two systems, the front-office staff has to enter basic registration information twice, and the billing staff still has to input codes from printed encounter forms. But Faistl notes that the group didn't purchase an EMR in order to reduce data entry. "Our problem was workflow and volume and the ability to track information." The EMR does what the practice wanted it to do in those areas, he says.

In contrast, a three-doctor endocrinology group in Vero Beach, FL, found that not being able to link their SOAPware EMR with their Lytec practice management system compounded their cash-flow problems. And poor support from a local vendor led to other problems with the software. So they switched to an integrated PM/EMR system from WebMD that improved office efficiency and boosted collections.

Unlike the New Jersey primary care group, the endocrinologists decided to build their EMR templates individually, notes Denise R. Tonner, one of the group's partners. This entailed a good deal of work, since they started with internal medicine templates and a few diabetes guidelines. But individual forms accommodated the differences in practice style between the partners. For instance, one types less than Tonner does and uses twice as many templates for office visits.

How you implement an EMR will depend on your goals, your specialty, the size of your practice, the complexity of your software, the type of equipment you use, and a host of other considerations. But there are a few points that apply to all practices:

■ First, implementation and training will cost between 20 and 33 percent of the total EMR outlay. It's self-defeating to try to bargain down vendors on this expense, says Rosemarie Nelson, a consultant in Syracuse, NY. Without proper training for the entire staff, your implementation effort will fall flat on its face.

■ Second, it's essential to have a physician champion who can convince his colleagues to do the hard work necessary to implement the EMR.

■ Third, decide in advance what your goals are and how you want to handle the change process, because the EMR will change the way everyone in the office works.

Here's how some practices have implemented their EMRs, along with advice from consultants and vendors.

Training and support: There's no substitute

Solo pediatrician Jeffrey D. Cooper of Duluth, GA, recalls that when his office was a testing site for its EMR (JMJ's EncounterPRO), his office staff got only four hours of formal training, but the trainer stayed on site for a week. As Cooper added nurse practitioners to handle a growing patient load, he had each of them follow him around for two weeks; the second week, they'd chart in the EMR while he examined patients.

Faistl says his group in New Jersey got 120 hours of training and implementation from NextGen. Between the time they bought the EMR and when they started using it, the vendor trained five or six practice managers and nonphysician clinicians in an on site conference room. "We then had those managers and clinicians train each of the physicians for an hour or two at a time, three or four times before we went live," says Faistl.

NextGen charges \$200 an hour for training and implementation, and most practices will need at least 100 hours, says Pat Cline, president of the software company. That time includes setting up the hardware and software.

Different employees need to learn different things, notes consultant Nelson. "The vendor should have specialized training for nurses, doctors, reception staff, and the people who import faxes and do scanning."

Vendors provide project managers only for larger groups, she adds. If you have a small practice, a nurse or administrator will have to make sure everybody stays on schedule, help train staff, and help doctors customize templates. "That person should have at least a week's worth of training by the vendor. And even with that, the vendor should still provide on site training support."

Implement all at once or in phases?

Many experts recommend a phased implementation of the EMR: First get your nurses and nonclinical staff up to speed, they say, before asking doctors to enter notes in the EMR.

"Some vendors like to start with messaging, call routing, and results reporting, because those are things that don't interfere in the exam room, and everyone can adapt at his own pace," notes Nelson.

If you now have a nurse or medical assistant record the patient's chief complaint, history, medications, allergies, and vital signs, she can learn to do that in the EMR before you see the patient. According to cardiologist John A. Saia, who's part of a 30-doctor cardiology group in southern New Jersey, having a

nurse enter problem and medication lists prior to visits helped the physicians in his office adapt to their Amicore EMR without reducing their productivity.

In some smaller groups, like Faistl's and Tonner's, all of the doctors began entering notes into point-and-click templates right away. But most groups allow doctors to adapt at their own rate. In the Central Utah Multi-Specialty Clinic, for instance, only about half of the 59 physicians were taking notes in their EMR two years after the go-live date—and that's considered a highly successful implementation. But whether they dictate, point and click, or do some combination of the two, all of the physicians are now viewing records online; the group went paperless a year after adopting its Allscripts TouchWorks EMR.

Vendors warn against trying to scan in all your old charts before going live. Most groups either scan key parts of charts before patients come in or enter the critical data into their EMR. Doing the latter is a lot more work than scanning, but the Roswell Pediatric Center in Alpharetta, GA, felt it was essential to enter data such as immunizations, meds, and allergies that doctors would need to access quickly. To do that in-putting, the 15-provider practice had to hire six extra people.

Even when doctors begin to take notes electronically, they'll have to pull paper charts until all of their patients have been in at least once. This usually takes three to six months, but could take twice that long in practices where patients may not come in more than once a year.

Template building: a breeze or a chore?

Before you implement your EMR, you and your colleagues should decide whether you want to design templates together or individually. Letting each doctor chart in his own way can be a problem when you're on call or when the practice has to defend its billing methods. Also, notes Ron Sterling, a computer consultant in Silver Spring, MD, if each doctor charts his own way, the EMR may not be able to pull together data on, say, all asthma patients in the practice, or whether all the doctors delivered certain services.

Even if your EMR comes with templates designed for your specialty, they may have been built by another group that practices or documents differently than yours. If a vendor developed the guidelines with in-house physicians, they won't be able to foresee every variation in workflow.

Physicians report varying degrees of difficulty in customizing EMR templates. Pediatrician Jeff Cooper did it "on the fly" in JMJ's EncounterPRO while seeing patients. Endocrinologist Denise Tonner, who'd already had experience on a simpler EMR, says it took her a couple of hours to design each of eight templates that she uses for most visits in WebMD's OmniDoc EMR. Internist Jeffrey W. Johnson of the Central Utah group figures he spent eight to 10 hours customizing templates for common conditions in TouchWorks.

Supposedly, you don't need special technical skills to build EMR templates, yet many doctors leave it to IT people or computer-savvy clinicians to make changes based on their suggestions.

Once these templates are finished, there are many ways to speed up charting in a well-structured EMR. You'll have "favorites" lists for often-used medications and diagnostic codes; you can incorporate portions of past notes; and you can chart by exception, entering only findings that differ from the norm.

Learning how to document electronically is not a technical challenge, says internist Mark K. Leavitt, an EMR pioneer who was recently named medical director of ambulatory care for the Healthcare Information and Management Systems Society. But for doctors and computers to mesh, he says, "the system must offer enough choices so the physician can find a tool that matches his needs."

That includes being able to go beyond point-and-click templates, he observes. "For routine visits, templates may work very well. But for other types of visits and specialties, you've just got to put in free text." Consequently, says Leavitt, most EMRs allow doctors to incorporate dictation (with or without voice recognition) and typing.

Bear in mind, however, that the benefit you get out of an EMR is proportional to the effort you put into it. The more free text you use, the less discrete data will be available to you. Moreover, Johnson points out that it's hard to get the benefit of better coding if the program doesn't have enough data to suggest E&M codes.

How an EMR affects workflow

Most physicians who have an EMR would acknowledge that it slowed them down a bit at first. But none of the practices we looked at lost productivity, even in the first weeks of implementation. Either the doctors worked an hour or two longer each day, or they took some work home with them until they felt comfortable charting in the exam room. A year or more after switching to EMRs, none reported working longer hours or seeing fewer patients. In fact, some said they were seeing more patients in the same amount of time.

By all accounts, clinical staffers love EMRs because it saves them time. Other employees also accept it once they know their jobs are not in jeopardy. "It's key that the staff knows you're not going to replace them with a computer," says Nancy Babbitt, administrator of Roswell Pediatric Center. "You're just trying to help them do their job better."

Vendors say that the only people laid off because of EMRs are file clerks in large groups. Even at Central Utah Multi-Specialty Clinic, only three records people were let go, while the number of providers increased 70 percent. The other clerks had plenty of work scanning documents.

In other practices, clerks have been promoted to billers, and billers are spending more time on collections.

On the other hand, Babbitt knows of a cardiology practice that, after buying an EMR, laid off 10 of 37 support staff, including people in filing, billing, and other clerical areas. So, whatever you do, don't lie to the staff. If you think you may be laying people off, don't tell them you won't be.

Implementing an EMR isn't a breeze, but with the proper training and support from vendors, a well-managed group with motivated physicians can overcome the obstacles in a relatively short period of time. The key to success is knowing what you want and figuring out how to get there.

Hitting the ground running

Roswell Pediatric Center in Alpharetta, GA, introduced most features of its Noteworthy EMR and IMPACT.MD document management system when the system "went live" in November 2001. The group, which includes nine pediatricians and six nurse practitioners, had two reasons for implementing everything at once, says practice administrator Nancy Babbitt.

First, the pediatricians were making a big investment that they wanted to recoup as soon as possible. Second, says Babbitt, "There's nothing more frustrating than to not be able to find a chart or a report. That was the biggest incentive."

The EMR vendor, Noteworthy Medical Systems, gave the whole staff two hours of off-site training. It also kept a dozen people on site for a couple of days, helping the triage nurses and teaching the physicians and NPs one on one. Babbitt worked with the administrative staff herself.

Babbitt, who served as the in-house champion and project manager, helped overcome physician resistance. "There were a few physicians who didn't want it, and we had one NP who really didn't want it. When everybody else got into it and got excited and saw what it could do for them, they eventually got caught up in it. But it didn't happen overnight."

For the first couple of weeks, notes Babbitt, the physicians were going home half an hour to an hour later each day. After that, most of them got up to speed, but it took one doctor a couple of months to catch up to the rest.

All of the clinicians suggested changes to the EMR templates, some of which were based on the practice's paper forms for checkups, asthma, and ADHD. Assisted by the group's IT person, a committee consisting of a doctor and two nurses made changes in the templates for the whole group. Except for chief complaints, which are typed in by nurses, and some comments on special features of a case, the clinicians now use the point-and-click method to take notes.

While the EMR is linked with the group's VitalWorks billing system, the group decided not to buy an interface with the scheduling module. That would have been nice for viewing schedules without having to toggle to another screen. Also, it would have allowed an EMR user to send recalls and reminders directly to the scheduler, but that can be done through the internal messaging system.

Although the IMPACT.MD document management system allows users to send messages to other users' task baskets (clinical "to-do" lists), the Noteworthy EMR lacks this feature. So the practice has cobbled the IMPACT.MD messaging together with the EMR's ability to notify doctors when a chart has been "held" for them to look at.

When the EMR was implemented, the group hired six temporary people to input key data from the old charts and also pulled paper charts for the doctors when patients visited for the first time after the go-live date. Clerks still input immunization and lab data, making them easier for doctors to find than if they were scanned. Documents from labs, hospitals, and consultants are scanned in.

Looking back on the experience, Babbitt says, "There isn't one EMR system that will do everything. So you pick the one that will do most of what you need, and then help that company develop the other things that are needed."

Phasing in a new EMR

Oswego County OB-GYN in Oswego, NY, acquired an integrated Greenway EMR and practice management system in December 2002. It took nearly a year to introduce all of the system's components.

It wasn't that the workflow of the practice—with four ob/gyns and four advanced practice nurses—was that complex, although it was scattered over four sites. But the PM system had to be implemented first, so as not to disturb billing and scheduling. Then the messaging and online lab results came in, cutting turnaround time for reviewing results to less than 24 hours from two or three days. Finally, in March 2003, some of the clinicians began charting gynecological patients on the EMR. That spread to the whole group by July, when the doctors began taking electronic notes on obstetrical patients.

Practice administrator Daniel Mather says the clinicians started with gynecology because they could start taking electronic notes on a patient-by-patient basis. For obstetrics, where the doctors have to cover for one another, they all had to be up to speed. The same applied to their customization of templates: Every clinician did his or her own thing on gynecological forms, but they worked together on the obstetrical templates.

Mather and two of the doctors—including Mather's brother Joseph—went to the headquarters of Greenway Medical Technologies in Carrollton, GA, to learn the system. The staff got their initial EMR training when they learned the PM system in a four-hour session, and the doctors were mostly trained in their off-hours.

All that was scanned into the EMR from the paper charts were the previous year's exam notes. When patients came in for a visit, they had a history taken, and the encounter was documented in the EMR.

How did the EMR affect the doctors' workflow? "They were a bit behind in the beginning, but now the EMR is saving them time," says Mather. "In the first few months, it slowed them down about 3 or 4 minutes per yearly exam. But it saved them time on charting after the visit. It saved a lot of time on the labs, because they were able to do them throughout the day, rather than dealing with a stack of them after-hours.

Doctors weren't allowed extra time to see patients, except when they were being trained. During that period, they could see two fewer patients a day. "Since then, they've seen more patients" in about the same time, says Mather.

Ken Terry. Getting an EMR up and running. *Medical Economics* May 7, 2004;81:TCP3.

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